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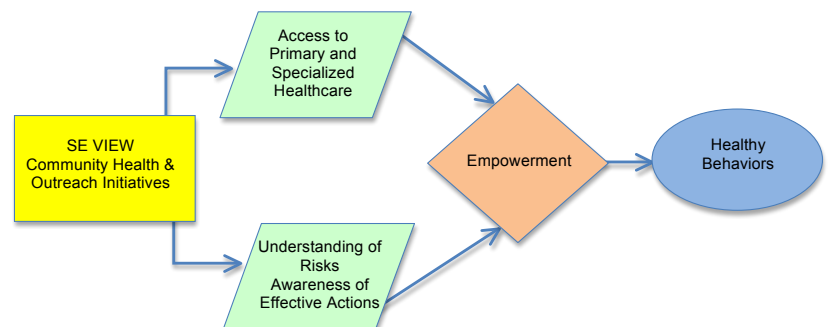
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Introduction to SE VIEW

South Carolina and other Southeastern states share a disproportionate burden of chronic diseases, including diabetes, hypertension, various cancers, metabolic syndrome and periodontal disease, which limit opportunities for individuals to enter military service. The rural nature of the region compounds issues of healthcare access and delivery. Racial, ethnic and socioeconomic disparities amplify incidence, prevalence and complications associated with chronic illness. With escalating healthcare costs impacting federal, state and employer budgets, the economic consequences of health disparities represent a key driver for effecting change, improving quality of care for many Americans and ensuring a military-ready population. The Medical University of South Carolina (MUSC) is addressing these burdens through the **Southeastern Virtual Institute for Health Equity and Wellness (SE VIEW)**. The vision of SE VIEW is to develop a nationally recognized, multidisciplinary, inter-professional team of researchers, educators, outreach professionals and laypersons to reduce health disparities. Sabra C. Slaughter, PhD, serves as the Principal Investigator (PI) of SE VIEW and Director of the SE VIEW Administrative Core (SEVAC). Dr. Slaughter and SEVAC provide comprehensive program planning, management, coordination, integration and evaluation. Overall, SE VIEW seeks to:

- Increase awareness of the underlying causes of chronic diseases in the region.
- Develop novel methods to engage communities in the prevention and treatment of chronic diseases.
- Develop community-based services and research initiatives focused on chronic diseases and socioeconomic factors.
- Develop a range of youth-based, active and interactive, electronic modalities to increase the prevention, detection and treatment of chronic diseases.

Figure 1. Conceptual Flow of SE VIEW's Plan to Reduce Health Disparities



SE VIEW operates as a model of cooperation to advance collaborative community-based research and service outreach initiatives designed to improve health conditions that preclude enlistment or reduce the functional tenure of military personnel. The flow concept is illustrated in **Fig. 1**.

SE VIEW Goals

- **GOAL A** - Integrate MUSC's model initiatives focused on health disparities into SE VIEW by identifying programmatic synergies and streamlining administrative processes.
 - **Objective A1:** Establish a single Administrative and Coordinating Core to oversee project logistics, financial transactions, regulatory compliance and bi-directional communications.
 - **Objective A2:** Establish an Evaluation & Tracking Core to monitor SE VIEW activities and provide timely feedback to the Principal Investigator, Initiative Directors and TATRC to improve program quality.
- **GOAL B** - Develop strategic partnerships and programs to address the burden of health disparities.
 - **Objective B1:** Establish an Educational Program to reduce health disparities.
 - **Objective B2:** Establish a Preventive Medicine, Health and Wellness Program to reduce health disparities.
 - **Objective B3:** Establish a Community Partnerships and Outreach Program to reduce health disparities.

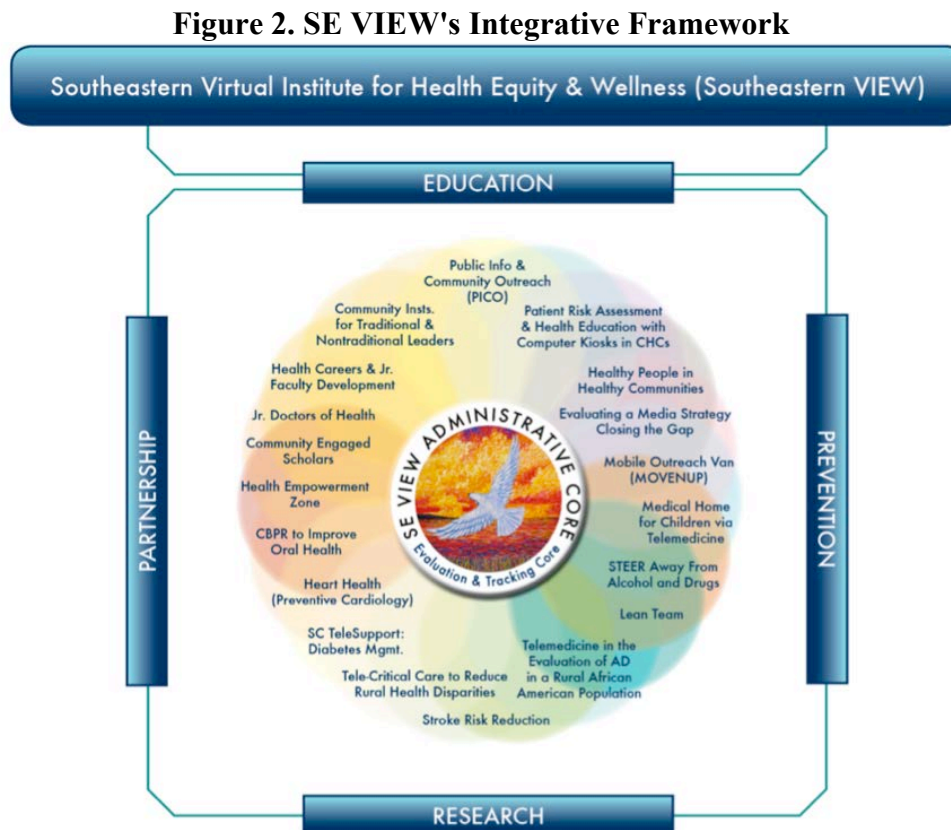
Body

SE VIEW Phase II, its Co-investigators and Administrative Core have completed Year 2 of the 6 additional community-based research and service outreach programs. The purpose of SE VIEW is to discover and deliver innovative health care and community capacity building solutions for underserved populations. An additional targeted outcome is to reduce the rejection rate as well as improve the enlistment opportunities and tenure of active duty military personnel.

The Administrative Core delivered operations, infrastructure access, strategic consultation, and quality process support to ensure proper directions, logistics, financial transactions, regulatory compliance, collaborative exchange, community-capacity building, and alignments with the goals of programmatic synergies and streamlining administrative processes and to foster strategic partnerships and programs to address the burden of health disparities.

An evaluation planning process, inclusive of an evaluation logic model to identify SE VIEW success objectives, continues to be developed and will be completed during Year 3 of Phase II and the Phase I no cost extension. SE VIEW programmatic activities, infrastructure, collaborative exchange and evaluation priorities/outcome measures will drive the Phase I NCE and the Phase II Year 3 advances and serve as foundational for SE VIEW achievement of its stated aims.

SE VIEW's community-based research and service initiatives are aligned under three program categories addressing **Education (B1)**, **Preventive Medicine, Health and Wellness (B2)**, and **Community Partnerships and Outreach (B3)**. **Fig. 2** illustrates SE VIEW's integrative framework.



A. Goal A – integrate MUSC’s model initiatives focused on health disparities into SE VIEW by identifying programmatic synergies and streamlining administrative processes.

A1. Objective A1 – establish a single Administrative and Coordinating Core to oversee project logistics, financial transactions, regulatory compliance and bi-directional communications.

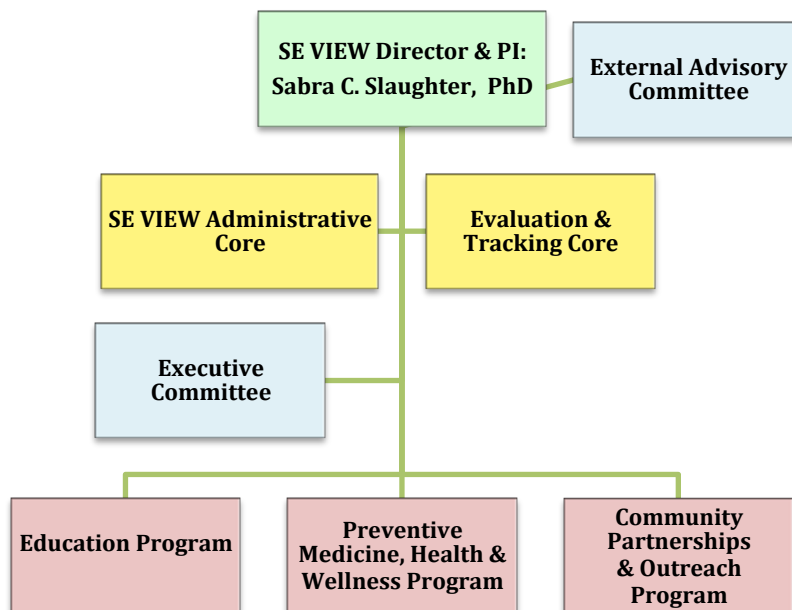
Effective leadership and management ensure that SE VIEW initiatives are fully realized. SE VIEW has strong support at the highest levels at MUSC. The Principal Investigator, Project Manager, Business Manager and Initiative Directors are highly capable individuals with the commitment, experience and authority to conduct SE VIEW.

A1a. Southeastern VIEW Administrative Core (SEVAC) Team:

- Jennifer Friday, PhD (Evaluation Consultant)
- Thomas Gordon, PhD (Strategic Planning Consultant)
- Sabra C. Slaughter, PhD (SE VIEW Principal Investigator)
- Tracey W. Smith, MHA (Program Manager)
- Garcia E. Williams (Marketing Consultant)
- Bart Yancey, MPA (Business Manager)

Fig. 3 shows the SE VIEW Organizational Chart. Key elements include a well-defined academic home, clear leadership, synergistic programs and committee structures. Individual initiatives are aligned under the three program headings. SEVAC ensures that lines of communication, agendas, actions and decisions are coordinated and targeted to the project goals and objectives. SEVAC staff coordinate activities across the region, convene committee and town hall meetings, host retreats, manage program logistics, and ensure overall operational efficiency.

Figure 3. SE VIEW Organizational Chart



A1b. Director and Principal Investigator

Sabra Slaughter, PhD, SE VIEW Principal Investigator, serves as Chief of Staff in the Office of the President of MUSC. He previously directed the SC Area Health Education Consortium (AHEC). Dr. Slaughter earned a PhD in psychology from the University of Michigan. Dr. Slaughter has extensive administrative experience in health professional education, outreach and workforce diversity. He has been PI of 9 major extramural projects

related to healthcare and health disparities. As Chief of Staff, Dr. Slaughter works closely with the MUSC Board of Trustees, President, Vice Presidents, Deans and Faculty. He has the authority to make institutional decisions and commitments in developing SE VIEW policies and procedures, and is authorized to manage the adoption and implementation of best practices.

A1c. Strategic Planning Consultant

SE VIEW has engaged TAGA Consulting, a strategic planning and consulting company, to help design, facilitate and support strategic planning and ongoing quality improvement processes. TAGA's founder and principal, Thomas A. Gordon, PhD, is a licensed psychologist with degrees from Harvard University and the University of Michigan. Dr. Gordon has provided strategic consulting services to public and private institutions including Aetna Healthcare, AT&T, Johnson & Johnson, Merck Pharmaceuticals, Siemens, US Army, US Dept. of Labor and US Postal Service. Responsibilities include collaborating on the design of the planning process, supporting the flow of information between SE VIEW initiative directors and key stakeholders to identify synergies and minimize barriers; developing processes to ensure effective communications, cultural sensitivity and shared focus on SE VIEW activities; and developing and guiding change management activities to support commitment to the SE VIEW plan.

A1d. Committee Structure

Internal and external committees facilitate coordination and accountability. Committee members and stakeholders will receive annual progress reports in addition to interim (quarterly and ad hoc) reports, plans and assessment materials.

Executive Committee (EC). The Executive Committee (EC), composed of the Initiative Directors, is SE VIEW's internal committee for communication, collaboration and management. The PI serves as chair, the Program Manager serves as Executive Secretary, and the Strategic Planning Consultant and Evaluation & Tracking Director are standing advisors. The EC holds bi-monthly 3.5-hr meetings (**Appendices 1-4**). Each meeting includes 2-3 scheduled 'stand-up' 15-min program reports on recent progress, challenges, alternatives, results and future directions as well as 3-min 'roundtable' updates from other program leaders. The EC's role is to ensure integration among initiatives, advise on issues common to all SE VIEW initiatives such as resource utilization, and see that SE VIEW milestones are met in a timely manner. The members are responsible for evaluation and tracking with direct input from the Evaluation & Tracking Director.

External Advisory Committee (EAC). The SE VIEW External Advisory Committee (EAC) is made up of one nationally recognized expert in health disparities (W. Timothy Garvey, MD), three civic/community leaders in SC (Vince Ford, Allen Parrott, D.Min, and Rita Scott), and one TATRC member (Wilbur Malloy, MA, MLS – Ex Officio Member). The purpose of the EAC is to review SE VIEW's impact, integration and productivity based on measurable progress toward goals and to advise SE VIEW leadership concerning scientific direction and results. They will review the performance of the PI and make recommendations for enhancing impact and effectiveness. EAC Community members, in tandem with SE VIEW Initiative Directors, will help create a plan for community education, outreach and advocacy that is responsive to the diversity, needs and interests of the communities served by SE VIEW. The EAC met during the October 2012 SE VIEW Annual Reception and Retreat that took place on October 17-18, 2012. The following lists the SE VIEW EAC member biographies:



Vince Ford

Mr. Vince Ford is Senior Vice President of Community Health at Palmetto Health in Columbia, SC. Mr. Ford is responsible for Palmetto Health's \$17 million tithe to the community for health issues. Mr. Ford had been working under the auspices of Richland Memorial Hospital since April 21, 1997. Prior to that, he was the Executive Director of the Boys and Girls Clubs of the Midlands. Mr. Ford is active in the community and has served as Director of the Sickle Cell Foundation

and as Chairman of Richland School District One School Board. The South Carolina School Boards Association named him Outstanding School Board Member for the Sixth Congressional District and All-State School Board Member. Mr. Ford also serves on the Benedict College Board and the University of South Carolina African American Community Advisory Board. Mr. Ford earned his Bachelor of Science in Sociology from Benedict College and Master of Science in Individual and Family Development from S.C. State University.



W. Timothy Garvey, MD

Dr. W. Timothy Garvey is Professor of Medicine and Chair of the Department of Nutrition Sciences at the University of Alabama at Birmingham. He obtained his MD degree, cum laude, from St. Louis University in 1978, and completed residency training in Internal Medicine at Barnes Hospital, Washington University, in 1981. He then was a clinical fellow in Endocrinology and Metabolism at the University of Colorado Health Sciences Center and University of California, San Diego School of Medicine. He subsequently held faculty posts at the University of California, School of Medicine (Assistant Professor), Indiana University School of Medicine (Associate and full Professor), and from 1994 to 2003 was the Director of the Division of Endocrinology, Diabetes, and Medical Genetics at the Medical University of South Carolina. Dr. Garvey moved to UAB on June 1, 2004.

Dr. Garvey has achieved international recognition for his research in the metabolic, molecular, and genetic pathogenesis of insulin resistance, Type 2 Diabetes, and obesity. His studies have involved the cellular and molecular biology of cell and animal models, metabolic investigations of human subjects on metabolic research wards, and the genetic basis of diseases in Gullah-speaking African Americans, Pima Indians, and national cohorts of diabetes patients. Dr. Garvey has directed an independent laboratory since 1987 supported by the National Institutes of Health (NIDDK, NHLBI), the Department of Veterans Affairs, the AHA, JDFI, the ADA, and other agencies. Dr. Garvey also has a track record of community based research and outreach in the context of two initiatives, Project Sugar (a genetics study among Gullah-speaking African Americans) and MUSC/HBCU Partners in Wellness (a program in community health at 6 historically black colleges and universities in SC intended to challenge minority students towards careers in the health professions).

He has provided service as a member of national research review committees for the Juvenile Diabetes Research Foundation, the American Diabetes Association, the VA Merit Review Program, and the National Institutes of Health. He was a standing member of the Metabolism Study Section at NIH from 1998-2002, and has chaired several ad hoc NIH study sections. Dr. Garvey currently serves on the editorial boards of Diabetes, and has previously served in this capacity for the Journal of Clinical Endocrinology and Metabolism and Diabetes Reviews. He is a member of the American Society for Clinical Investigation, the Association of American Physicians, the Endocrine Society, and the American Diabetes Association, and the North American Association for the Study of Obesity.



Allen W. Parrott, D.Min

Dr. Allen W. Parrott is the Presiding Elder of the Kingstree District in the Seventh Episcopal District of the African Methodist Episcopal Church. He has been involved in health ministry and the role of the church in addressing health needs of the people. Dr. Parrott has also developed workshops and has written several publications focusing on lay ministry and the class leader in Methodism. Among them are: 1) Class Leaders Training Workshop, a six-hour intensive training that focuses on the biblical, historical and theological understanding of the class leader ministry, 2) Empowering The Laity for Effective Ministry and Service: A Message And A Ministry, and 3) Empowering Class Leaders for Effective Ministry. Dr. Parrott is a 1971 graduate of Mayo High School, Darlington, South Carolina. He graduated from Allen University (Columbia, SC) in 1975 with a Bachelor of Arts degree. He earned a Masters of

Divinity degree from Turner Theological Seminary in Atlanta, GA (1979), and a Doctor of Ministry degree from Erskine Theological Seminary (Due West, SC). Dr. Parrott is married to Barbara Ann Canty Parrott of Sumter, South Carolina. They are the proud parents of three children, Kevin Eugene (Erica), Korey Allen (Autumn), Kimberly Rochelle and two grandchildren, Kendall and Jayden.



Rita L. Scott

Mrs. Rita L. Scott is the Vice President and General Manager of WCSC-TV5. This station is the CBS affiliate in Charleston and the number one station in ratings and revenue. WCSC is also the number one web/mobile platform in the Lowcountry. In 2010, the station launched a second digital channel “Live 5 Plus” and in September 2011 launched “Bounce” the first over the air network targeting the African American community on its third digital channel.

Mrs. Scott is active in the community, serving on numerous Boards to include Spoleto USA, International African American Museum (Vice Chair), Trident United Way, Regional CEO Council, and is also a member of the Nielsen Alliance. In 1999, Mayor Riley and the City of Charleston honored her as the first African American woman to become General Manager of an affiliate television station, naming October 21 in her honor.

Mrs. Scott was born in High Point, North Carolina. Her career in the broadcasting field began in sales with WGHP Television, Greensboro/High Point, North Carolina. She has held numerous positions in television sales including positions with WJW in Cleveland, Ohio and Cap Cities/ABC National Sales in Chicago, Illinois before eventually moving back to the Carolinas as Local & National Sales Manager at WBTV in Charlotte. Mrs. Scott attended High Point College and Appalachian State University with studies in Speech Communications with a Broadcast Concentration and a Business Minor.



Wilbur W. Malloy, MA, MLS (ASCP) SBB

Mr. Malloy is a retired Army Officer (Lieutenant Colonel, Medical Service Corp) and during his 23 years of military service directed numerous clinical laboratories and blood banking facilities. He has received numerous awards and accolades to include the Legion of Merit. Wilbur is a disabled Vietnam-era veteran and served in Operation Desert Shield/Desert Storm in Saudi Arabia. During his last military assignment, he served as the Laboratory Manager for the Department of Pathology and Area Laboratory Services at the Walter Reed Army Medical Center, Washington DC. Currently, Wilbur is the Portfolio Director for Blood Products and Blood Safety and serves as a Program Director for the Telemedicine and Advanced Technology Research Center (TATRC) at the United States Army Medical Research and Materiel Command (MRMC), Fort Detrick, MD. TATRC

manages approximately 500 million dollars in medical research for the Department of Defense and Wilbur has utilized his 30 plus years of experience in healthcare and military medicine to identify, explore and demonstrate key technologies and biomedical principles required to overcome technology barriers that are both medically and militarily unique. Wilbur has contracting officer representative responsibilities for projects in the areas of computational biology, bio monitoring, blood products and safety, regenerative medicine, nano-medicine and biomaterials, medical logistics, infectious disease, wellness and training, and genomics and proteomics. Mr. Malloy has completed graduate studies at the University of Maryland and is a graduate of Pepperdine University (Malibu, CA) with a Master’s Degree in Healthcare/Research Management and North Carolina A&T State University (Greensboro, NC) with a Bachelor of Science degree in Professional Biology. He is a

registered Medical Laboratory Scientist/Medical Technologist and Specialist in Blood Banking and Immunohematology.

A2. Objective A2 – Establish an Evaluation & Tracking Core to monitor SE VIEW activities and provide timely feedback to the Principal Investigator, Initiative Directors and TATRC to improve program quality.

An evaluation planning process, inclusive of an evaluation logic model to identify SE VIEW success objectives, continues to be developed and will be completed during the FY14 NCE. SEVAC continues to engaged Jennifer C. Friday, PhD, of The Friday Consulting Group, to provide expertise and guidance in designing and implementing the Evaluation Plan. Dr. Friday is a behavioral scientist with >25 years' experience in researching and evaluating health and education programs. She received her BS in biology from Millikin University, and master's and doctoral degrees in psychology from the University of Tennessee, Knoxville. For 13 years she worked at the CDC in programs dealing with HIV/AIDS and violence prevention. Dr. Friday's policy development skills were honed at the Joint Center for Political and Economic Studies in Washington, DC. She has facilitated workshops and training programs, devise strategic plans, and guided program planning and evaluation for government agencies, community-based organizations, and for-profit and non-profit entities, including Community Health Outreach Works, Inc., Alliance for Christian Media, Oakhurst Community Health Center, and the Rosalynn Carter Institute for Human Development.

The evaluation consultant will: (a) develop the logic model; (b) identify key success indicators and measures for each initiative; (c) develop the evaluation plan and framework for the overall SE VIEW project; (d) keep performance indicators and data collection focused on measures of success; (e) demonstrate the value of increased effectiveness and efficiency; (f) utilize quality improvement methods to achieve evaluation aims; and (g) work with participants on how to utilize evaluation data. The SE VIEW Evaluation Plan includes process, outcome and impact evaluation. The impact evaluation will be designed now as part of the Evaluation Plan, and implemented at a future date when SE VIEW is completed and/or integrated into the community.

Process Evaluation. The process evaluation will document and analyze implementation of the project. This includes identification and integration of the individual initiatives into the overall SE VIEW project. Data collection methods will include document reviews such as quarterly reports, minutes from bi-monthly project meetings, key informant interviews and observations. Data and information from the process evaluation component will be used to provide feedback to improve services on an ongoing basis.

Outcome Evaluation. The outcome evaluation of the project documents whether the project goals and objectives were met. The outcome evaluation will address the degree to which the project was successful in achieving measurable, positive results in the key outcome goals of the project. Specifically, the outcome evaluation is designed to document the project's degree of success in conducting the outcome evaluation. Both quantitative and qualitative data will be collected and analyzed. The outcomes for the evaluation are divided into short-, medium-, and long-term objectives. The short-term objectives focus on increasing the knowledge base of the participants, the medium term objectives focus more on behavior change while the long-term objectives are focused on the overall outcomes for the program.

Impact Evaluation. The impact evaluation component will focus on the extent to which the SE-VIEW activities made a difference in the target community. This will include changes in community health status, improved access to care, and general improvement in health delivery systems. The impact evaluation will be designed as part of the evaluation plan, but it is not expected that this will be a part of this current project. Impact evaluations will be implemented at a future date once the project is completed and has had some time to become integrated into the community.

Data Plan

The evaluation will utilize both qualitative and quantitative data. Qualitative data will include document reviews, individual interviews, focus groups and surveys. Quantitative data will be collected through implementation activities, participation rates, self-report questionnaires, curriculum assessments, and other program activities.

Data will be gathered utilizing a variety of methods and modalities. Utilizing multiple data sources is critical because of the variety of activities that each of the projects will be engaging in. This will help to facilitate gathering a variety of information that will be helpful in understanding how the program is being implemented and the progress towards achieving the program outcomes.

Baseline data will be collected by each of the SE-VIEW projects at the outset. These baseline data will be summarize for use by SE-VIEW as the starting point for the overall evaluation. Process evaluation data will be ongoing and additional data to support the process evaluation will be collect quarterly or as needed for the established reporting system. Outcome data will be collected once a year during the project period.

In addition to the data collected by the individual projects, the overall SE-VIEW project will also collect data to supplement the information received. Data collection methods will include the following:

- **Case Studies**

Case studies of SE-VIEW projects may be conducted to take a thorough look at the steps needed to develop, implement, and evaluate the project. This would provide an in-depth description about what is needed for effective service delivery and achievement of outcomes.

- **Document Reviews**

Analysis of documents that include but are not limited to program records, research reports, census data, health records, as well as newspaper and magazine articles. Paper and computerized archival data will be collected and analyzed, attendance at all program functions will be recorded and monitored, and site visits by members of the evaluation team will be used to provide feedback on the fidelity of implementation

- **Focus Groups**

Focus Groups with subsets of the communities beings served, participants, partners and others will be conducted to gather in-depth information related to the activities of SE-VIEW.

- **Interviews**

Data will be collected with in-person or telephone interviews and with targeted focus groups. This will provide qualitative data that will be incorporated into both the process and outcome components of the evaluation.

- **Medical Assessments and Tests**

An assortment of medical assessments and diagnostic tests will be administered by the SE-VIEW projects. These include, but are not limited to blood pressure readings, hemoglobin A1C, cultures.

- **Observations**

Observe situations, behaviors and activities in a formalized and systematic way, usually using observational checklists and trained observers.

- **Surveys and Written Data Collection Instruments**

Data will be collected through the use surveys that will be collected in a variety of ways including in-person, online, phone and mail. These surveys may be developed for the individual programs or may be existing standardize measures. We will also utilize program logs and other data collection methods use as part of the regular program activities. In addition, evaluation staff will participate in project meetings and other program activities where their presence will not interfere with program delivery or data collection. Paper and computerized archival data will be collected and analyzed, attendance at all program functions will be recorded and monitored, and site visits the evaluation team will be used to provide feedback on the fidelity of implementation.

Data Analysis

The mixed model nature of the data to be collected will require a variety of data analysis methods. Data will be analyzed using standard statistical packages and will include descriptive and inferential statistics. The data analysis will be developed as the final program plans are approved and implemented.

Institutional Review Board Submission Plan

Phase I projects needing IRB approvals were submitted to local IRB. Once they received approval, they were then submitted to the Human Subject Protection Office at the US Army Medical Research and Material Command in Ft. Detrick, MD for its approval. The process varied in length for the different projects. As part of the process evaluation, a survey is being developed to learn more about the approval process and to determine ways to streamline the process. This information will be used to help guide the Phase II projects.

Evaluation Logic Model

The following logic model provides the framework for the SE-VIEW Evaluation Plan. The vision and goals of SE-VIEW have been established. In the model, we identify each of the projects and link them to the specific goals. Two separate evaluation plans have been developed for Phase I and Phase II. It is anticipated that once all the projects have received IRB approvals and are in their implementation phase that the Evaluation Plans will be combined.

The inputs necessary for SE-VIEW to be successful have been identified. There are several SE-VIEW activities that are listed. They include instructional and research activities, outreach and service activities, health care delivery and prevention services, as well as policy activities. The communities that are targeted are the I-95 Corridor and the Coastal Carolina communities, with some specific focuses on Johns Island, the Sea Island Gullah population and Williamsburg County. These communities represent all the racial and ethnic populations and socio-demographic groups that are affected by health disparities.

The broad range of outcomes has been identified. These will become more specific and targeted as the individual projects begin implementation of their activities. The outcomes that directly relate to SE-VIEW are incorporated into the overall evaluation plan. Similarly, the data sources that have been identified are drawn from the individual projects.

The general evaluation questions are stated. As the projects get off the ground and begin the full implementation, it is anticipated that there would be additional evaluation questions that will need to be asked. Additional indicators will also be identified as we progress through the implementation of the project, and as the program activities become better defined. **Table 1** illustrates the SE VIEW II Evaluation Logic Model.

Table 1. SE VIEW Evaluation Logic Model (Phase II)

SE VIEW VISION

To develop a nationally recognized multidisciplinary, inter-professional team of researchers, educators, outreach professionals and laypersons to eliminate health disparities.

SE VIEW GOALS & OBJECTIVES

Goal A: Integrate MUSC's model initiatives focused on health disparities into the SE VIEW by identifying programmatic synergies and streamlining administrative processes.

Objectives:

A1: Establish a single Administrative and Coordinating Core to oversee project logistics, financial transactions, regulatory compliance, and bi-directional communications.

A2: Establish an Evaluation and Tracking Core to monitor SE VIEW activities and provide timely feedback to the Principal Investigator, Initiative Directors and TATAC to improve program quality.

Goal B: Develop strategic partnerships and programs to address the burden of health disparities.

Objectives:

B1: Establish an Educational Program to reduce health disparities: Program initiatives will focus on increasing awareness of health issues in communities that bear a disproportionate burden of chronic diseases, and address educational deficits related to chronic diseases. SE VIEW Projects linked to this goal:

- MUSC Public Information and Community Outreach Initiative (PICO)
- Community Institutes for Traditional and Nontraditional Leaders
- Our Health Series: Made-For-TV Dialogues

B2: Establish a Preventive Medicine, Health and Wellness Program to reduce health disparities: Program initiatives will expand proven strategies and/or develop novel methods to engage communities, and remove barriers to effective healthcare. SE VIEW Projects linked to this goal:

- Providing a Medical Home for Underserved Children in Williamsburg County via Telemedicine

B3: Establish a Community Partnerships and Outreach Program to reduce health disparities: These activities will provide the foundation for integrated efforts to address chronic disease burden in populations that could provide talented recruits for military service, and disseminate evidence-based research findings. SE VIEW Projects linked to this goal:

- STEER Away From Alcohol and Drugs
- Evaluating a Media Strategy – Closing the Gap, Inc.
- CBPR to Improve Oral Health
- Junior Doctors of Health
- Patient Risk Assessment and Health Education with Computer Kiosks in Community Health Centers
- Healthy People in Healthy Communities

INPUTS

Churches/Faith-Based Organizations, Clinics/Health Centers, Emergency Dept., Federal Clinics, Funding Support, Government Agencies, Grocery Stores, Healthcare System, Hospitals Materials (Training Tools, Evaluation), MUSC, Health Clubs, PTO, Restaurants, Schools, SE VIEW Consultants, SE VIEW Projects, staff, tools and worksites

OUTPUTS**Activity**

Community Engagement, Consultation, Cultural Exchange, Healthcare, Health Promotion, Health Career Academy, Instructional, Mentoring, Networking, Outreach, Policy, Prevention, Research, Screening, Service, Training, Web and Internet, Wellness Council

Target Population

Communities, I-95 Corridor, Coastal Carolina, Groups: African Americans, Community Leaders, Elderly, Obese Children, Rural Population, School Aged Children, Teenagers

OUTCOMES**Short Term**

Increase knowledge base; increase skills and awareness

Medium Term

Utilization of knowledge base

Long Term

Increase positive behaviors; decrease in negative behaviors

DATA**Data Sources**

Activity Logs, Attendance Logs, Behavioral Risk Factor Surveillance System, Census Data, Clinic Data, Community Members, Community Partners, Comorbidity (DRGs & ICD-9), Council of Governments, De-Identified Ref. Lists, Follow-Up Records, Federally Qualified Health Centers Patient Electronic Care Sys. (FQHC - PECS), Partners, Hospital Discharge Data, Institutional Data, Land Developers, Medicare/Medicaid Data, Meeting Agendas, Meeting Minutes, MUSC Faculty, MUSC Students, Neighborhood Assoc., Office Of Vital Records Participant Logs, Program Data, Program Faculty, Program Participants, Public Access Info, Registration Forms, SC Dept. of Health, SC Off. Of Res. & Statistics, School Attendance Zones, School Data, Secondary Sources, Standardized Media Contact Form, Store Audit Survey, Structured Activity Form, Telephone Logs, Transportation Authority, Web “Hits”, Working Group Reports, Youth Risk Behavioral Surveillance System

Data Collection Methods

Case Studies, CDC Change Questions, Clinical Screenings, Current Resource List, Focus Groups, Interviews, Key Informant Interviews, Medical Assessments/Tests, Observation, Organizational Assessments, School Cafeteria Audits, Screening Tools, Service Delivery, Surveys –General, Tests/Assessments,

	Walkability Survey, Windshield Survey Data Collection Measures Clinical Dementia Rating Scale, Clock Drawing Test, Continuing Educ. Credits, Depression (PHQ-9), Diabetes Fatalism Scale, Diabetes Knowledge Questionnaire, Diagnostic Evaluations, Essential Medical Tests/Screens (Hemoglobin A1C; Blood Pressure; Cultures; Body Mass Index; Lipids Profile), Geriatric Depression Scale, Health Literacy, Logical Memory IIA, Medical Comorbidity (Charlson Index), Mini Mental State Exam, Modified Hachinski Ischemia Scale, Morisky Medication, Adherence Scale Patient Demographics Survey, Perceived Diabetes Self Efficacy Scale, Quality of Life Measures, Resource Use, Social Support, Standard Clinical Assessment, Summary of Diabetes, Self-Care Activities Scale, Supportive Care Measures
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EVALUATION QUESTIONS

Process Evaluation Questions	Outcome Evaluation Questions	Impact Evaluation Questions
<u>Inputs</u> How many resources (human and financial) are needed to achieve goals? Who will implement the program? Who provided program services? What are the characteristics of coalitions, collaborations, partnerships, etc.? Are the resources adequate? <u>Activities</u> How many programs/sessions/activities delivered? What services/activities were provided? Was the curriculum delivered as intended? Are implementation objectives being attained? What was the quality of the delivery (consistency and fidelity)? <u>Target Population</u> How many participants are in the program? How many participants are in each session/activity? What is the participant's level of satisfaction with the program/activity? What were the facilitators to implementation?	<u>Increase Knowledge</u> Did knowledge increase? <u>Change Behavior</u> Did we have behavioral changes? <u>Achieve Outcomes</u> Was programmatic integration achieved? Were strategic partnerships established? Are outcome objectives being achieved? Did the projects/interventions improve access to services? Did the projects/interventions improve the quality of services provided?	Which aspect of the program contributed more to the outcomes? Are there unintended outcomes? Are participants satisfied with program implementation and outcomes? What changes have participants made as a result of the program? Who does the program affect directly and indirectly? Who benefits from this program and how? Are the program's results worth the resources?

INDICATORS

Levels of participation, levels of service and activity, levels of support, establishment of advisory groups, listing of community programs and services, evidence of partnership activities, achievement of objectives, changes in knowledge/behavior, changes in vending machine choices, changes in physical activity, improved nutrition, increase in DASH-type meals, research productivity, reduction in health indicators, increased access to healthcare services

B. Goal B - Develop strategic partnerships and initiatives to address the burden of health disparities.

MUSC has substantial strengths serving the goals of education, prevention, community partnership and research to eliminate health disparities. These include a dynamic and diverse faculty, outstanding facilities, a strong and diverse student body, and many existing community ties. Building on these strengths, SE VIEW has identified and integrated robust programs focused on the elimination of health disparities to ensure a military ready workforce, retention of active duty personnel, and continued health in VA health services.

As shown in **Fig 2.**, SE VIEW's community-based research and service initiatives are aligned under three program categories addressing **Education (B1)**, **Preventive Medicine, Health and Wellness (B2)**, and **Community Partnerships and Outreach (B3)**. The alignment of initiatives with these objectives is based on primary thrust and specific goals of each project. However, all the programs use resources and tools that integrate educational, disease prevention/health promotion, and community engagement principles.

To illustrate SE VIEW's synergies, thematic interactions and potential for administrative efficiencies, **Tables 2-4** chart all the SE VIEW initiatives as programmatic clusters with respect to three integrative concepts: **Stages of Life, Community Engagement and Empowerment Strategies, and Disease Targets.**

Table 2. SE VIEW's Comprehensive Plan to Reduce Health Disparities across the Lifespan

italics = funded in SE VIEW Phase I

boldface = new/funded in Phase II

Objectives/Approaches	Stages of Life		
	Children	Adolescents	Adults
B1 EDUCATIONAL PROGRAMS TO REDUCE HEALTH DISPARITIES			
B1a Public Information and Community Outreach (PICO)			
<i>B1b Community Institutes for Traditional and Nontraditional Leaders</i>			
<i>B1c Health Careers Academy & Junior Faculty Development</i>			
B1d Junior Doctors of Health			
B2 PREVENTIVE MEDICINE, HEALTH AND WELLNESS PROGRAMS			
<i>B2a Stroke Risk Reduction Initiative</i>			
<i>B2b Heart Health Initiative (Preventive Cardiology Research)</i>			
B2c SC TeleSupport (Diabetes Management Initiative)			
<i>B2d Tele-Critical Care to Reduce Rural Health Disparities</i>			
B2f STEER Away from Alcohol and Drugs			
B2g Providing a Medical Home for Underserved Children via Telemedicine			
B3. COMMUNITY PARTNERSHIPS AND OUTREACH PROGRAMS			
<i>B3a Lean Team Initiative</i>			
<i>B3b Community Engaged Scholars – Collaborations in CBPR</i>			
<i>B3c Mobile Outreach Van (MOVENUP) Initiative</i>			
<i>B3d Health Empowerment Zone</i>			
B3e Healthy People in Healthy Communities			
<i>B3f Telemedicine in the Eval. of AD in a Rural, African American Population</i>			
B3g Evaluating a Media Strategy – Closing the Gap			
B3h CBPR to Improve Oral Health Disparities			
B3i Patient Risk Assessment & Health Ed. w/ Computer Kiosks in CHCs			

Key Research Accomplishments, Reportable Outcomes, Conclusion and References

The purpose of the Phase II Annual Report is to provide a summary of SE VIEW achievements in strengthening and expanding its scope by incorporating 6 additional projects. The following is a high level overview of these 6 initiatives included in Phase II:

- **Junior Doctors of Health**

JDOH uses a comprehensive strategy targeting children, adolescents, teachers and parents. With the leadership of the research team, MUSC students serve as instructors/mentors in a dynamic curriculum, teaching children to track eating and exercise habits. Teachers serve as healthy role models, participating with the children in exercise programs and pedometer competitions. Parents are active participants in workshops and family health activities. JDOH also teaches adolescents about health-related careers and offer service-learning experiences. The research team has identified measurement sets for process evaluation as well as pre- and post-survey tools for impact evaluation, and work closely with the SE VIEW Evaluation & Tracking Core to finalize. (Scotty Buff, PhD, MPH, Department of Library Sciences and Informatics)

- **STEER Away from Alcohol and Drugs**

This project uses a multifaceted approach: **S**creening, **T**raining, **E**ducating, **E**valuating, and **R**eferral for treatment. Specific aims are to: screen individuals at local health fairs, community centers and other community facilities for alcohol and drugs, using evidence-based questionnaires; train multidisciplinary professionals (nurses, social workers, psychologists, physicians, physician assistants) to assess, evaluate and treat alcohol and drug use in patients in various clinical settings; educate middle and high school students, adults and individuals in treatment/recovery, using evidence-based tools; evaluate the impact of STEER on participants' knowledge base and behaviors, as well as the impact on health indices of patients seen by trained healthcare professionals participating in the STEER program; and refer patients identified as having an alcohol or drug use disorder to appropriate treatment. (Deborah Deas, MD, MPH, Professor, Department of Psychiatry and Behavioral Sciences)

- **Providing a Medical Home for Underserved Children in Williamsburg County via Telemedicine**

This project uses telemedicine technology to extend and enhance the local healthcare infrastructure in rural, underserved Williamsburg County in the I-95 Corridor. A medical home-focused initiative allows local providers, in collaboration with MUSC personnel, to see their patients in a school setting. Through face-to-face teleconferencing with exam capabilities in the school setting, children will have access to a medical home with regularly scheduled preventive care visits as well as sick care as needed. MUSC provides a referral clinic for specialty needs. (James T. McElligott, MD, MSCR, Assistant Professor, Department of Pediatrics)

- **Evaluating a Media Strategy - Closing the Gap, Inc.**

This initiative evaluates the impact of a communication strategy to deliver evidence-based health information to medically underserved, rural and urban African Americans, including a unique group, the Sea Island Gullah population, with distinctive cultural practices and language patterns containing many words of West African language origin. The research team has identified process evaluation metrics and are working with the Evaluation & Tracking Core to complete the evaluation plan. (Marvella E. Ford, PhD - Associate Professor, Department of Biostatistics and Epidemiology)

- **CBPR to Improve Oral Health**

Specific aims are to promote sustainable oral care self-management practices, improve availability of preferred oral healthcare options, and incorporate advanced technology in dental restorative procedures. The investigators and Johns Island community members have conducted a formative study and are ready to implement a multi-level, socioculturally tailored intervention that targets identified barriers to oral care. This initiative uses a community-based participatory research (CBPR) approach to design and test a multi-level intervention including church-level strategies, group-based education and community-based oral health promoters. (Renata S. Leite, DDS, MS - Assistant Professor, Department of

Stomatology/Periodontics)

- **Patient Risk Assessment and Health Education with Computer Kiosks in Community Health Centers**

This initiative implements an innovative use of health computer kiosks to promote patient self-assessment of risk factors in a community clinic setting. The desired outcomes include improved accuracy of patient perception of disease risk factors, more effective patient/provider interactions, increased patient self-efficacy and health knowledge, and ultimately healthier lifestyle behaviors. (Arch G. Mainous, PhD - Professor, Department of Family Medicine and Biostatistics)

PROJECT TITLE: Junior Doctors of Health

DIRECTOR: Scotty Buff, PhD

The mission of Junior Doctors of Health (JDOH) is to promote wellness in underserved populations by creating “Junior Doctors of Health,” youth empowered to take control of their own health, pursue career interests, educate their families, friends, and communities about healthy eating and exercise.

The program is implemented in sites that educate underserved youth in Charleston and across the state. Through JDOH, Medical University of South Carolina (MUSC) and University of South Carolina (USC) student mentors teach youth about healthy choices, suggest ways to make changes to their current diet and physical activity, and encourage youth to explore healthcare professions with the goal of ultimately eliminating health and education disparities in this population. JDOH uses a comprehensive strategy with pipeline aspirations to target youth, teachers and parents. MUSC/USC students serve as instructors/mentors in a dynamic curriculum, teaching youth to track eating and exercise habits. Teachers serve as healthy role models, participating in exercise programs and nutrition classes. Parents are active participants in workshops and family health activities. Additionally, through partnerships with local middle school J-ROTC instructors, a Leadership program has been created for 7th and 8th grade students. The program, entitled the MUSC Junior Doctors of Health Leadership Program (LP), includes a unified curriculum that is delivered by both the J-ROTC instructors and MUSC Student Mentors. The J-ROTC instructors cover Leadership Theory and Application, Foundations For Success, and Wellness, Fitness, and First Aid. The MUSC Student Mentors meet with the LP students regularly to provide tutoring in areas of academic need such as mathematics and literacy to promote academic success and to deliver interactive health promotion activities.

As part of the SE VIEW project, the JDOH program meets *Goal B: To develop strategic partnerships and programs to address the burden of health disparities*; and more specifically, *Objective B1: Establish an Educational Program to reduce health disparities*. Program initiatives focuses on increasing awareness of health issues in communities that bear a disproportionate burden of chronic diseases and address educational deficits related to chronic diseases. The project’s goal is the prevention of childhood obesity and seeks to target youth on multiple levels through direct (youth education) and indirect (teacher, parent, and community outreach) methods. The following information provides details regarding specific program activities with military relevance, as well as the reach of JDOH program:

Youth Pipeline. Alarming statistics regarding the prevalence of overweight and obesity affect the military from recruitment to retention to combat readiness. Seventy-five percent of Americans aged 17-24 are unable to join the military with the leading medical cause being overweight or obese. This statistic is especially staggering when considering 50% of youth enter the military or consider entering the military. To address this national security issue, the DOD has made changes in daycares, schools, and military base life to improve the health and nutrition of military families. Between 1995 and 2008, the percentage of potential recruits who failed their physical exam because of being overweight rose by almost 70% (Neibuhr, Cavicchia, Bedno, Cowanm, & Barker et al., 2009).

In addition to obesity affecting military recruitment efforts, overweight active-duty personnel have been found to be more likely to leave military service because of failure to meet weight standards before finishing their contracted period. Over 1,200 first-term enlistees leave early each year because of being overweight (Dall, Zhang, Chen, Wagner, Hogan, Fagan, Olaiya, & Tornberg, 2007). In order to replace these 1,200 enlistees, the military must recruit and train replacements at a cost of \$50,000 for each man and woman or at a cost of \$60 million a year. In addition to obese active-duty personnel leaving their military service early, overweight or obese active-duty personnel are found to have higher absenteeism rates as well as more days with below-normal productivity than those who are not overweight (Dall et al., 2007). The link between the need for childhood obesity prevention efforts to ensure success of the military is clearly evident.

To address childhood obesity, JDOH works with pre-K to 8th grade youth in seven Charleston County School District (CCSD) schools serving predominately low income, African American youth. Additionally, JDOH is taught to rural and low-income youth across SC through collaborations with the SC Area Health Education Consortium (SC AHEC) and the University of South Carolina (USC). Tables 5-8 summarize the re-vamped JDOH youth curriculum that was delivered during the 2012-2013 school year. As shown in Table 6, 737 youth received the program across the state.

Table 5: Summary of the 5th-8th Grade Curriculum

Session 1: Healthy Eating and Limiting Sugar-Sweetened Beverages		
Station 1: Review of MyPlate	Station 2: Review Health Beverages	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Introduction to the MyPlate Deliverables: • Emphasis on making half of your plate filled with fruits and vegetables. • Make at least half of your grains whole grains. Try eating more beans, peas, tofu, nuts and seeds. 	<ul style="list-style-type: none"> • Review the amount of sugar in popular beverages. • Deliverables: • Drink water to replace sugar sweetened beverages such as soda and sweet tea. • Switch to fat free or 1% milk • Limit consumption of 100% fruit juice to ½ cup per day. 	<ul style="list-style-type: none"> • Fruit smoothie taste testing. Youth create a health goal related to healthy eating or healthy drinking.
Session 2: Wise Exercise and the Body		
Station 1: Exercise and Limit Screen Time	Station 2: Human Body and Sugar Sweetened Beverages	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Review the Exercise Pyramid. • Deliverables: • Aim for at least 60 minutes of exercise each day. • Limit screen time to less than 2 hours per day. Sports are a great way to get in your 60 minutes of daily exercise. 	<ul style="list-style-type: none"> • Review the human body model and the affects of sugar sweetened beverages on the organs. • Deliverables: • Excessive sugar has negative effects on the body. • It is important to consume water especially when exercising. • Avoid sports drinks and other sugar sweetened beverages. 	<ul style="list-style-type: none"> • Vegetable snack tasting. Youth create a health goal related to exercise and limiting screen time.

Session 3: Health Profession Exploration		
Station 1: Health Professions	Station 2: The Human Body	Conclusion/Additional Activities
Student mentors discuss their health profession and answer questions from the youth about their field.	Human body model demonstrations of bodily functions (e.g. the heart pumping blood).	Healthy beverage tasting. Review goals from the previous two sessions.
Session 4: Youth Advocacy		
Introduction	Create Advocacy Project	Share Advocacy Poster
Discussion of advocacy. JDOH review.	Each youth has the opportunity to create a health message to display in their classroom, school or community.	Youth present their advocacy poster in front of their peers.

Table 6: Summary of the 2nd-4th Grade Curriculum

Session 1: Healthy Eating and Limiting Sugar-Sweetened Beverages		
Station 1: Review of MyPlate	Station 2: Review Health Beverages	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Introduction to the MyPlate Deliverables: • Emphasis on making half of your plate filled with fruits and vegetables. • Make at least half of your grains whole grains. • Try eating more beans, peas, tofu, nuts and seeds. 	<ul style="list-style-type: none"> • Review the amount of sugar in popular beverages. • Deliverables: • Drink water to replace sugar sweetened beverages such as soda and sweet tea. • Switch to fat free or 1% milk • Limit consumption of 100% fruit juice to ½ cup per day. 	<ul style="list-style-type: none"> • Fruit smoothie taste testing. • Youth create a health goal related to healthy eating or healthy drinking.
Session 2: Wise Exercise and the Body		
Station 1: Exercise and Limit Screen Time	Station 2: Human Body and Sugar Sweetened Beverages	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Review the Exercise Pyramid. • Deliverables: • Aim for at least 60 minutes of exercise each day. • Limit screen time to less than 2 hours per day. • Sports are a great way to get in your 60 minutes of daily exercise. 	<ul style="list-style-type: none"> • Review the human body model and the affects of sugar sweetened beverages on the organs. • Deliverables: • Excessive sugar has negative effects on the body. • It is important to consume water especially when exercising. • Avoid sports drinks and other sugar sweetened beverages. 	<ul style="list-style-type: none"> • Vegetable snack tasting. • Youth create a health goal related to exercise and limiting screen time.
Session 3: Health Profession Exploration		
Station 1: Health Professions	Station 2: The Human Body	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Student mentors discuss their health profession and answer questions from the youth about their field. 	<ul style="list-style-type: none"> • Human body model demonstrations of bodily functions (e.g. the heart pumping blood). 	<ul style="list-style-type: none"> • Healthy beverage tasting. • Review goals from the previous two sessions.
Session 4: Youth Advocacy		
Introduction	Create Advocacy Project	Share Advocacy Poster
Discussion of advocacy. JDOH review.	Each youth has the opportunity to create a health message to display in their classroom, school or community.	Youth present their advocacy poster in front of their peers.

Table 7: Summary of the Kindergarten-1st Grade Curriculum**Session 1: Fruits and Veggies on MyPlate**

Book Reading/Activity	Station 1: Seedling in a Bag	Station 2: Fruit and Veggie Food Origin Activity	Conclusion/Additional Activities
<ul style="list-style-type: none"> Read the book, <u>The Vegetables We Eat</u> by Gail Gibbons. Invite youth to say their name and a fruit or vegetable that begins with the same letter as their name. 	<ul style="list-style-type: none"> Review that fruits and vegetables need sun and water to grow by planting a lima bean in a bag with water. <p>Deliverables:</p> <ul style="list-style-type: none"> Fruits and veggies begin as seeds. Fruits and veggies need sun in order to grow. Fruits and veggies need water to grow. 	<ul style="list-style-type: none"> Youth draw fruits and vegetables in the MyPlate food group worksheet. <p>Deliverables:</p> <ul style="list-style-type: none"> Half of your plate should be filled with fruits and vegetables. The more color and variety, the better! Include fruits and vegetables in your snack and meals every day. 	<ul style="list-style-type: none"> Fruit and veggie taste testing. Youth sing, “Fruit and Veggie” song.

Session 2: Discover Dairy and Grain Food Groups

Intro/Activity	Station 1: Book and Whole Grain Craft Activity	Station 2: Book and Dairy Activity	Conclusion/Additional Activities
<ul style="list-style-type: none"> Ask youth to share something they remembered from the first session. 	<ul style="list-style-type: none"> Read the book, <u>Little Red Hen</u> by Jerry Pinkney. Youth create a picture of the little red hen using whole grains. <p>Deliverables:</p> <ul style="list-style-type: none"> Grains include bread, rice, and crackers. It is important to consume whole grains. There are many different types of grains including quinoa, barley, and couscous. 	<ul style="list-style-type: none"> Read the book, <u>The Milk Makers</u> by Gail Gibbons. Youth draw dairy foods and the animals that produce dairy foods. <p>Deliverables:</p> <ul style="list-style-type: none"> Yogurt, cheese, milk and ice cream are examples of dairy products. Switch to 1% or unflavored skim milk. Try to consume reduced fat or low-fat cheese. 	<ul style="list-style-type: none"> Dairy snack taste-testing.

Session 3: Wise Exercise

Book Reading	Station 1: Healthy Beverages, Exercise and The Body Model	Station 2: “Which Food Group Do I Belong To?”	Conclusion/Additional Activities
<ul style="list-style-type: none"> Read the book, <u>Henry Gets Moving</u> by Pierre Rouzier and Chaz Nielsen. Youth brainstorm (and act out) exercise activities Henry can engage in to reach 60 minutes everyday. 	<ul style="list-style-type: none"> Review the body parts and how drinking water and exercising improves body function using the plastic body model. <p>Deliverables:</p> <ul style="list-style-type: none"> Exercise for 60 minutes every day. Limit screen time to less than 2 hours per day. Drink water instead of soda and juice. 	<ul style="list-style-type: none"> Youth use the SmartBoard to drag each food item into the correct food group on the MyPlate. <p>Deliverables:</p> <ul style="list-style-type: none"> Half of your plate should be filled with fruits and veggies. There are many different types of whole grains! Consume low-fat or fat-free dairy products. 	<ul style="list-style-type: none"> Healthy beverage taste-testing. Youth review their favorite body part and point to where it is on their bodies.

Session 4: Exploring Health Professions and Advocacy Activity			
Introduction	Station 1: Health Profession Exploration	Station 2: Advocacy Project	Conclusion/Additional Activities
<ul style="list-style-type: none"> Review what it means to be a “Junior Doctor of Health”. 	<ul style="list-style-type: none"> Student Mentors describe their health professions and share their favorite book. Student mentors engage youth in an activity related to their health profession. 	<ul style="list-style-type: none"> Ask youth to draw a picture of what being healthy means to them to share with their family, friends, and community. 	<ul style="list-style-type: none"> Whole grain snack taste-testing. JDOH graduation ceremony.

Table 8: Summary of the Preschool Curriculum

Session 1: Fruits and Veggies on MyPlate			
Book Reading/Activity	Station 1: Fruits and Veggies on MyPlate	Station 2: Fruit and Veggie Food Origin Activity	Conclusion/Additional Activities
<ul style="list-style-type: none"> Read the book, <u>Eating the Alphabet</u> by Lois Elhert. Invite youth to say their name and their favorite fruit or vegetable. 	<ul style="list-style-type: none"> Review which food models are fruits and vegetables. <p>Deliverables:</p> <ul style="list-style-type: none"> Half of your plate should be filled with fruits and vegetables. The more color and variety, the better! Include fruits and vegetables in your snacks and meals every day. 	<ul style="list-style-type: none"> Review the connection between whole fruits and vegetables and other ways they are consumed. <p>Deliverables:</p> <ul style="list-style-type: none"> Fruits and veggies are used to make many different types of foods! Fruits and veggies are grown in gardens. Don’t be afraid to try new vegetables! 	<ul style="list-style-type: none"> Fruit and veggie taste testing. Youth and student mentors recite “I Say Fruits and Vegetables” poem.
Session 2: Wise Exercise			
Book Reading/Activity	Station 1: Human Body Model and Exercise	Station 2: Creating a Healthy Meal	Conclusion/Additional Activities
<ul style="list-style-type: none"> Read the book, <u>Get Moving with Elmo</u>. Youth participate in “freeze dance” exercise activity. 	<ul style="list-style-type: none"> Review the plastic human body model and how the organs are affected by exercise. <p>Deliverables:</p> <ul style="list-style-type: none"> Exercise for 60 minutes every day. Water is the best thirst quencher (especially when exercising!). Drink water instead of soda and juice. 	<ul style="list-style-type: none"> Youth create a healthy meal using the plastic food models. <p>Deliverables:</p> <ul style="list-style-type: none"> Half of your plate should be filled with fruits and vegetables. Desserts including pie, cookies, and cake are a “sometimes” food and should not be eaten every day. Drink water instead of soda and juice. 	<ul style="list-style-type: none"> Cucumber water taste-testing.
Session 3: Discover Dairy			
Book Reading	Station 1: What is Dairy?	Station 2: Animal Food Origin Activity	Conclusion/Additional Activities
<ul style="list-style-type: none"> Read the children’s book: <u>Milk: from Cow to Carton</u> by Aliki. 	<ul style="list-style-type: none"> Fruit, vegetable, and dairy group sorting activity. <p>Deliverables:</p> <ul style="list-style-type: none"> Foods that are made from milk are dairy products. 	<ul style="list-style-type: none"> Review what food products come from which animal. <p>Deliverables:</p> <ul style="list-style-type: none"> Eggs come from chickens. Milk comes from cows. 	<ul style="list-style-type: none"> Healthy dairy snack taste-testing.

<ul style="list-style-type: none"> • Yogurt, cheese, milk and ice cream are examples of dairy products. • Switch to 1% or unflavored skim milk. • Yogurt comes from milk (cow). 			
Session 4: Grain Group			
Book Reading	Station 1: Meal Creation Activity	Station 2: Advocacy Project	Conclusion/Additional Activities
<ul style="list-style-type: none"> • Read <u>Little Red Hen</u> by Jerry Pinkney. • Review what the little red hen could make with her wheat using the food models. 	<ul style="list-style-type: none"> • Youth create a healthy meal using the plastic food models. <p>Deliverables:</p> <ul style="list-style-type: none"> • A healthy meal using the food models. • An unhealthy meal using the food models. • Invite the youth to explain why the meal is either healthy or unhealthy. 	<ul style="list-style-type: none"> • Ask youth to draw a picture of their favorite healthy meal. 	<ul style="list-style-type: none"> • Whole grain snack taste-testing. • JDOH graduation ceremony.

An informal process evaluation was conducted to monitor the success of the re-vamped curriculum. Additionally, Student Mentors provided feedback as to how the activities, books, and snacks were operating in the classroom and made suggestions for improvements when applicable. Based on the results of the process evaluation and feedback from the Student Mentors, the curriculum is currently being broken down by grade level to include more interactive health promotion activities and to provide further variation from grade to grade.

To provide continual support and leadership opportunities to youth as they become older, a partnership was formed to enhance the self-advocacy of healthy lifestyles and personal academic success. This year, JDOH staff continued to partner with the J-ROTC instructors at the Burke Middle High school to unify the MUSC Junior Doctors of Health Leadership Program (LP). In 2011-2012, we conducted the pre-pilot, MUSC Junior Doctors of Health Leadership Program (LP), which focused on Leadership Theory and Application, Foundations For Success, and Wellness, Fitness, First Aid, and the JDOH youth curriculum. In the summer of 2012, JDOH staff continued to work with the J-ROTC instructors to combine the different components of the program into a unified curriculum delivered by both the J-ROTC instructors and MUSC student mentors that was presented in the fall of 2012. In December of 2012, the J-ROTC instructors and JDOH staff met to de-brief about the fall semester and decided to incorporate tutoring in areas of academic need such as mathematics and literacy into the LP to promote academic success. MUSC Student Mentors supplemented the tutoring activities with interactive health promotion activities delivered over the course of eight meetings for each grade level. The J-ROTC instructors continued to cover Leadership Theory and Application, Foundations for Success, and Wellness, Fitness, and First Aid. The unified curriculum is currently being revised to include a service-learning component within the health promotion activities such as showcasing a health promotion activity during a Parent Night to provide additional opportunities to build leadership skills.

As shown in Table 9, forty-seven 7-8th grade youth participated in the LP. A total of 784 youth and adolescents received the JDOH program across the state compared to 562 youth and adolescents who were reached the previous year.

Table 9: Statewide Reach of JDOH Curriculum by Region in 2012-2013

Location (Collaborator)	Youth	Adolescents in Leadership Program
Low Country	353	47
Pee Dee AHEC	110	-
Mid-Carolina	251	-
Upstate AHEC	23	-
Total	737	47

To evaluate the LP for success and impact, we have submitted the DOD IRB application so that we can conduct a formal evaluation. MUSC and the Charleston County School District have approved our IRB application to evaluate the LP for success and impact. We plan to begin collecting data during the beginning of the second semester of the 2013-2014 school year.

Parents. Resources to build wellness and academic success should follow a child home. To address this important facet of our pipeline, this year we provided education to parents through wellness workshops to support obesity prevention in the home. Parents participated in hands-on activities, making easy, cheap, and fast meals and snacks in addition to receiving information about diet and sampling health food. By spending resources focusing on the health of parents who are either overweight or at risk for being overweight, JDOH is addressing the strong social stigmatization that is associated with obesity among adults (Puhl & Latner, 2007). There is extensive literature documenting that obese adults face social disadvantages including employment, education, healthcare, and interpersonal relationships (Brownwell, Puhl, Schwartz, & Rudd, 2005 as cited in Puhl & Latner, 2005). Having a parent who is overweight has been shown to be a predictor for the child becoming overweight (Hood, Moore, Sundarajan-Ramanurti, Singer, Cupples & Ellison, 2000). Parents' knowledge of nutrition and their levels of physical activity are influential in their child's development of habits (Lindsay, Sussner, Kim & Gortmaker, 2006). Parents serve as role models by supporting healthy eating and exercise behaviors in the home.

The JDOH program facilitated Parent Workshops taught by MUSC Dietetic Interns covering topics including: Healthy Holiday Cooking, Healthy Soul Food, Grocery Shopping on a Budget, and Healthy Summer Grilling. The Parent Workshops were offered at the Charleston Progressive Academy, James Simmons Elementary/Memminger Elementary, the Neighborhood House (a community center serving parents whose children attend Sanders Clyde Elementary and Mitchell Elementary, Meeting Street Academy, and Parent University (a parent event coordinated by the Charleston County School District.) Table 10 reflects that during the 2012-2013 academic year, 124 parents were reached compared to 93 parents that were reached the previous year.

Table 10: Parents Participating in JDOH Parent Workshops in the Fall of 2012 and Spring of 2013

School	Fall 2012	Spring 2013	Total Parents Reached
Charleston Progressive Elementary	23	21	38
James Simons/Memminger Elementary	-	12	12
Meeting Street Academy	10	25	33
Neighborhood House	6	11	17
Parent University	24	-	24
Total	63	69	124

Teachers. Teachers are a child's early role model and a teacher who believes personal wellness is important is more likely to convey a positive attitude regarding healthy eating and exercise in the classroom.

To support teacher wellness, JDOH offered free weekly exercise and nutrition classes at the JDOH site locations during the fall and spring. As depicted in Table 11, thirty-five teachers participated in the program in the fall and sixteen participated in the spring. The monthly nutrition lessons are delivered by MUSC Dietetic Interns that focus on incorporating nutrition education in the classroom. During the previous year, thirty-seven teachers participated in the fall and thirty-six teachers participated in the spring. This decrease is due in part to exercise instructor turnover mid-year and school personnel re-structuring. We are currently exploring options to re-vamp the teacher program in order to reach more teachers.

Table 11: Teachers Participating in JDOH Exercise Class

School	Total Teacher Number [Ave per class]	
	Fall 2012	Spring 2013
Charleston Progressive Elementary	14 [9]	4 [3]
James Simons Elementary	7 [4]	5 [3]
Meeting Street Academy	5 [3]	-
Memminger Elementary	3 [3]	4 [4]
Mitchell Elementary	6 [3]	3 [3]
Total	35 [8]	16 [3]

MUSC Student Mentors. The JDOH youth sessions are delivered by students from the six colleges at the Medical University of South Carolina (MUSC), dietetic interns, and University of South Carolina (USC) students. This year there have been a total of 221 student mentors delivering JDOH via five channels: the Interprofessional Service Learning Projects (ISLP), an elective offered at MUSC and USC (IP 707), an elective offered at USC (HPEB 620), the Volunteer Program, and a Physical Therapy Course (PT 727) as depicted in Table 12. This past year, we have increased the number of professions represented in the JDOH program to 19 compared to 7 professions last year and included 221 student mentors this year compared to 138 last year.

Table 12: JDOH Student Mentors by Academic Degree Program and Method of Participation.

Degree Program	AHEC	MUSC/USC elective	USC elective	Volunteer	PT Course	Total by Degree Program
	ISLP	Addressing Childhood Obesity	Nutrition Through the Life Cycle	LP/JDOH	Cardiovascular and Pulmonary	
Dental Medicine	-	1	-	-	-	1
Dietetic Internship	14	-	-	-	-	14
Graduate Studies	-	-	-	1	-	1
Health Professions-PA	23	1	-	-	-	24
Health Professions-MHA	-	1	-	2	-	3
Health Professions-PT	1	1	-	-	64	66
Medicine	-	9	-	17	-	26
Nursing	7	1	-	-	-	8
Pharmacy	32	2	10	1	-	45
Biology	-	-	1	-	-	1
Business	-	-	3	-	-	3
English	-	-	1	-	-	1

Physical Activity and Public Health	-	-	1	-	-	1
Public Health-Health Services, Policy Management	-	-	1	-	-	1
Public Health, Health Promotion, Education & Behavior	-	-	1	-	-	1
Exercise Science	-	-	11	-	-	11
Public Health	-	-	9	-	-	9
Social Work	-	-	3			3
Psychology	-	-	1	-	1	2
Total	77	16	42	23	65	221

Military Relevance: Obese youth become obese adolescents and adults. The US Armed Forces are recruiting from an increasingly overweight pool. Failure to meet weight standards is the top reason for medical disqualification for service. Our initiative includes strong collaboration with J-ROTC instructors, starting in 7th grade, as part of a comprehensive pipeline program. We will continue to work closely with the Charleston County School District (CCSD) J-ROTC instructors to support the LP focusing on academic success, leadership, character building and health by providing MUSC Student Mentors to tutor in areas of academic need and engage LP students in interactive health promotion activities.

KEY RESEARCH ACCOMPLISHMENTS:

- Further unified the curriculum with the J-ROTC instructors to meet the needs of the Leadership Students at the Burke Middle High School.
- Hosted strategic planning meetings with LP collaborators that included J-ROTC instructors, middle school guidance counselor, and USC evaluation consultants.
- Piloted the re-vamped LP program in the spring.
- Piloted the re-vamped youth curriculum for all grade levels in Charleston and across the state.
- Held meetings with teachers to provide summary reports from last year's classroom sessions (See **Appendix A** for example).
- Received IRB approval from MUSC and the Charleston County School District.
- Submitted the DOD IRB application.

REPORTABLE OUTCOMES:

- Launched the JDOH website (www.musc.edu/JDOH).
- Developed a formal collaboration with Charleston Southern University's Health Promotion and Kinesiology Department to provide students with the opportunity to deliver the JDOH program to youth in their community starting in the fall of 2013.
- Partnered with the College of Charleston to provide internship opportunities for Public Health undergraduate students in future fall and spring semesters starting in the fall of 2013.
- Partnered with College of Charleston's Center for Partnership to Improve Education to offer an internship opportunity to an Education Major undergraduate student who aligned the re-vamped JDOH curriculum to state education and core standards.
- Piloted a successful new exercise program, Parent and Child Exercise (PACE) funded by MUSC's YES Family Fund.
- Extended the "Addressing Childhood Obesity using Community Approaches" (IP 707) course to USC.

- Offered the JDOH program as the class project in the USC course, “Nutrition through the Lifecycle” (HPEB 620) thereby increasing the number of health professions represented in the JDOH program and increasing the number of underserved youth in Columbia who receive the program.
- Provided the JDOH curriculum as a class community project for Physical Therapy students during the summer of 2013 thereby reaching more youth in the community.

CONCLUSION:

America’s childhood obesity rates have tripled in the past 30 years. Today, nearly one in three youth are overweight or obese, a problem that follows them through to adulthood. Studies cite that 80% of youth age 10-15 who were overweight became obese by 25 and youth overweight by 8 are more likely to have severe adult obesity. Unfortunately, obese youth become obese adolescents and adults, so the US Armed Forces are recruiting from an increasingly overweight pool.

During the second year of implementation through the SE VIEW project, JDOH has delivered the dynamic childhood obesity curriculum to 784 youth and Leadership Program students, delivered nutrition education to 124 parents, and provided Teacher Exercise and Nutrition classes to teachers at 5 schools.

Additionally, we have continued to monitor the revised JDOH curriculum throughout the year and are currently working on improvements such as breaking the lessons down by grade level and including more interactive activities. We have strengthened our collaboration with the J-ROTC instructors by creating a unified Leadership Program. The unified LP curriculum reflects a close collaboration between JDOH staff and J-ROTC instructors at Burke Middle High School, providing a program that enhances the existing JDOH curriculum with J-ROTC principles and providing tutoring to promote academic success. As the J-ROTC principals have been proven effective and military relevant, we provided lessons on health-related topics, tutoring to promote academic success, and service-learning projects to promote leadership skill development. We plan to evaluate the program for success and impact during the upcoming school year.

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PROJECT TITLE: STEER Away From Alcohol and Drugs

DIRECTOR: Deborah Deas, MD

Project STEER addresses health disparities in access, education, and treatment of the use and misuse of alcohol and other drugs in the minority, rural, under-served and at-risk population in Charleston, Dorchester, Berkeley counties and along the I-95 corridor, including Williamsburg County. The project addresses: education, prevention, partnership and research. **Aim 1:** To screen approximately 75 minority, rural, underserved individuals (18 years and older) each year at local health fairs, community centers and other community facilities' for risky alcohol and drug use. **Aim 2:** To provide a resource brochure of Charleston, Dorchester, Berkeley counties and I-95 corridor local treatment centers to access services for drug and alcohol abuse. **Aim 3:** To educate community leaders and counselors via educational workshops, continuing education conferences, and community-based venues. **Aim 4:** To train key personnel at community locations to perform screening and referral on their own: "Train the Trainer".

KEY RESEARCH ACCOMPLISHMENTS:

- **Received IRB Approval** in November 2012.
- **Developed local resource brochures of alcohol and drug treatment centers in Charleston, Dorchester, Berkeley counties and along I-95 corridor to include:**
 - Medical University of South Carolina, Institute of Psychiatry, Center for Drug and Alcohol Programs (CDAP), Charleston, SC
 - Medical University of South Carolina, Adolescent Substance Use Skills Education Training (ASSET), Charleston, SC
 - Charleston Center, Charleston, SC
 - Dorchester Alcohol & Drug Commission, Summerville, SC
 - Ernest E. Kennedy Center, Moncks Corner, SC
 - Beaufort County Alcohol & Drug Abuse Department, Beaufort, SC
 - Circle Park Behavioral Health Services, Florence, SC
 - Clarendon Behavioral Health Services, Manning, SC
 - Tri-County Commission on Alcohol & Drug Abuse
 - Dawn Center, Bamberg, SC
 - Dawn Center, Orangeburg, SC
 - New Life Center, Allendale, SC
 - New Life Center, Hampton, SC
 - New Life Center, Ridgeland, SC
 - Sumter Behavioral Health Services, Sumter, SC
 - Williamsburg County Department on Alcohol & Drug Abuse, Kingstree, SC
 - Free Support Groups
 - Alcoholic Anonymous, Charleston, SC
 - Alcoholic Anonymous, Columbia, SC
 - Alcoholic Anonymous, Walterboro, SC
 - Narcotics Anonymous, Charleston, SC
 - Narcotics Anonymous, Orangeburg, SC
- **Developed educational series to accommodate the resources provided by National Institute on Drug Abuse and National Institute of Health resource materials**
 - Series I - The Science of Addiction
 - Youth Session – "Family Addiction – Who killed My Grandfather?"
 - Parent Session – "What is Addiction?"
 - Series II - Shattering the Myths of Drugs
 - Youth Session – "What Your Friends Don't Know!"
 - Parent Session – "What Your Children Don't Want You Know!"

- Series III - Drug & Alcohol Facts
 - Youth Session – “The Truth and Nothing But The Truth”
 - Parent Session – “Commonly Used Drugs and Street Names”
 - Church Session – “He Comes to Steal, Kill & Destroy”
- **Utilized Turning Point Technologies for anonymous polling** of addiction series questions.
- **Notified and scheduled sessions** on the networking opportunities in the community where the alcohol and drug screening, and education will occur.
 - South Carolina Area Health Education Consortium
 - Angelica Christie – Director, Health Careers Program
 - Health Careers Program Coordinators
 - Natasha Chatman – Low Country AHEC
 - Nita Donald – Upstate AHEC
 - Erica Davis – Mid Carolina AHEC
 - Larissa Clavon – Pee Dee AHEC
 - Anna Tecklenburg, MA, Program Coordinator, Hispanic Health Initiatives & Office of Practice - Hispanic Migrant Outreach Program, College of Charleston
 - Romina McCandless, MPH, Program Coordinator, Charleston, Berkeley and Dorchester Counties - Perinatal Awareness Successful Outcomes (PASO) – Latino Community based program of the South Carolina Public Health Institute.
 - Jabra Communications El Solo 980-1480 Hispanic Radio Broadcast (Listeners 2000-4000) – Dr. Marcelo Lopez, MUSC ; “Addiction Issues within the Hispanic Community”
 - Lisa Potts, Executive Director, Parents Anonymous – “Leading the Way 2013 Conference “ – Communities In School
 - Margie Gamble, PHR, Training Specialist – Department of Human Resources at Charleston County Government
 - Robert Seay, Director of Student Affairs – The Arts Institute of Charleston
 - Juanita Jefferson, Counselor – Pineland Girls Home, Summerville, SC
 - LaToya Dodson, Brashier Middle College Charter High School, Greenville, SC-Health & Wellness Seminar
 - Pinkey Carter, Nurse Director, South Carolina State University, Orangeburg, SC – Training Sessions for Drug Use Screening

REPORTABLE OUTCOMES:

The research team has devised an algorithm for community outreach and developed the target population and timeline for the first year. The algorithm will assist the research team in screening, evaluating, resources, educating and training.

The goal for Project STEER is to educate seventy-five (75) participants in addiction and adverse effects of drugs and alcohol abuse as well as provide a self-report screening test of Drug Abuse Screening Test and Alcohol Use Disorders Identification Test to seventy-five participants.

Aim 1: Screened

Over the course of the year, the Project STEER Team exceeded its goal of screening seventy-five participants to screening one hundred seventy-eight participants through the education component of the project.

- One hundred seventy-eight (178) participants took the Drug Abuse Screening Test (DAST-10)
- One hundred seventy-eight (178) participants took the Alcohol Use Disorders Identification Test (AUDIT)
- 36% of four hundred twenty-six educated participants completed the self-report version of Drug Abuse Screening Test (DAST-10)

- 36% of four hundred twenty-six educated participants completed the self-report version of Alcohol Use Disorders Identification Test
- 100% of 12 participants completed only the self-report version of Alcohol Use Disorders Identification Test

Aim 2: Local Resource Brochures

The two hundred ninety one (291) local resource brochures were distributed to participants through the education series and health fairs.

Aim 3: Educational and Resource Materials

Again, the Project STEER Team exceeded its goal of educating seventy-five (75) participants to educating four hundred twenty-six (426) participants about the adverse effects of drugs and alcohol through the developed education series throughout South Carolina to include colleges, high school and organizations.

In addition, one thousand four hundred and ninety-four (1494) National Institute on Drug Abuse materials were distributed as follows through education series and health fairs.

- Science of Addiction – 247 copies
- Shattering the Myths of Drugs – 162 copies
- Commonly Abused Drugs – 103 copies
- Drug Facts: Bath Salts – 231 copies
- Drug Facts: Synthetic Marijuana – 215 copies
- Drug Facts: Marijuana – 204 copies
- Drug Facts: Alcohol – 192 copies
- La Ciencia De La Adiccion – 33 copies
- La bebida y su embarazo – 27 copies
- La marihuana – 25 copies
- La mezcla de bebidas alcoholicas – 30 copies
- Estrategias para reducir el consumo de alcohol – 25 copies

Aim 4: Train the Trainer

Project STEER was able to provide a training session to the student health nurses of South Carolina State University in the Screening for Drug Use in General Medical Settings (NIDA, 2011). Among other things, this program trains participants in use of self-report measures of drug and alcohol use. The University will be using these screenings as a source for identifying misuse of drugs and alcohol and proactive treatment through the student-counseling center.

CONCLUSION:

Alcohol and other drugs of abuse have negatively impacted the lives of many, and the lack of education about the effects and the knowledge of what to do to access treatment contribute to the overall burden of illness. Alcohol abuse is one of the leading causes of essential hypertension, leading to higher rates of heart disease and stroke, two very important health disparities in African Americans. Project STEER addresses the health disparities in access, education, and treatment of the use and misuse of alcohol and other drugs in the minority, rural, under-served and at-risk population in the Tri-County (Charleston, Dorchester, and Berkeley) as well as Williamsburg County along the I-95 Corridor.

Our research group is making progress towards screening, educating and providing resource materials local treatment centers information throughout South Carolina. We will continue working with the community to improve ongoing identification of drug and alcohol misuse in our underserved communities.

REFERENCES:

- National Institute of Health, National Institute of Alcohol abuse and Alcoholism
- U.S. Department of Health and Human Services, National Institute of Health
- National Institute on Drug Abuse

PROJECT TITLE: Providing a Medical Home for Underserved Children in Williamsburg County via Telemedicine

DIRECTOR: James T. McElligott, MD

Distinguishing Characteristics and Program Description: This project will use telemedicine technology to extend and enhance the local healthcare infrastructure in rural, underserved Williamsburg County in the I-95 Corridor. A medical home-focused initiative will allow local providers, in collaboration with MUSC personnel, to see their patients in a school setting. The rural geography and limited number of providers in the county restrict the availability of in-person visits for many children, leading to increased morbidity and elevated health care costs. Through face-to-face teleconferencing with exam capabilities in the school setting, children will have access to a medical home with regularly scheduled preventive care visits as well as sick care as needed. MUSC will provide a referral clinic for specialty needs. While school-based telemedicine initiatives occur throughout the country, this initiative is unique in that it targets a rural area, engages the county healthcare infrastructure, and emphasizes the importance of a medical home. Williamsburg County is ideal for this project as the leadership and stakeholders in the area display a strong sense of individualism, pride, and motivation to improve. The area is situated for growth through an accessible interstate and has untapped potential for recreation and tourism. A recent report by RTI International lists targeting health disparities as one of six key recommendations for improvement in the area, with special attention on the need for primary preventive care for children. The Telemedicine Medical Home is intended to reach children who do not have an existing provider, and will be constructed with goals of equal access to local providers to minimize redundancy of care and maximize efficiency of existing resources.

Military Relevance: The program will provide needed primary health care to a geographically isolated region. The future health of our nation is largely dependent on the healthcare our children receive. Many future military recruits will be from medically underserved, rural areas. This program will address disparities in healthcare by coupling telemedicine technology with the central focus of preventive care, the medical home. It will also compare the utility of a mobile telemedicine unit to be used at multiple sites vs. fixed-site telemedicine units. The efficient use of telemedicine for cost-effective delivery of high quality healthcare to remote areas is highly relevant to military needs and interests.

- Aim 1: Determine the proportion of telemedicine visits that are for publicly insured patients or patients who have no insurance.
- Aim 2: Determine the proportion of telemedicine visits that are successfully completed without the need for in-person evaluation.
- Aim 3: Determine the utilization of the telemedicine program over time as a rate of use per month.

Relationships, strategies, and initiatives were established and set in motion last year, and the following efforts have been made during this recent period:

- Progress this year includes an ongoing presence by Dr. McElligott on the state Telehealth Work Group and as a board member of the newly formed Palmetto Care Connections (state telehealth network). As a relevant example, a draft legislative bill to mandate telemedicine reimbursement is now seeking sponsorship. This legislation would expand the services available to these school based clinics. Dr. McElligott has also been highly involved in the development of outpatient specialty consultation programs, many of which may well be relevant improve the lives of rural children with health conditions.

- Telemedicine equipment was purchased, delivered, and installed at 2 Williamsburg County schools and 2 Williamsburg county provider sites, though one provider site has subsequently closed. These tasks were completed with cooperation from MUSC IT staff and school IT specialists.
- Nurse practitioners and school nurses were trained in the use of the telemed equipment, and consults are underway. To date there have been 70 school-based telemedicine consults, including the urban pilot site. All three active sites have participated in visits.
- School nurse training and year-end program evaluations were conducted by Dr. McElligott in videocam meetings. Suggestions and assessments made by the nurses were reviewed and implemented.
- A scientific abstract was presented at a national meeting regarding the pre-intervention data and access barriers to care in the rural regions of South Carolina.
- Dr. McElligott moderated a session on primary care telemedicine at the national meeting for the American Telemedicine Association.
- A plan for patient enrollment has been established, which includes community engagement through school registration and PTO meetings, as well as the creation of social media presence, most likely linked to the current SE VIEW site. School nurses participated in a teleconference to organize these activities prior to school ending for the year.
- Hemingway Elementary School was added to the school based telemedicine sites, and the Affiliation Agreement was signed and filed.
- Dr. McElligott and Dr. Summer are working on an analysis of the health access patterns in the I-95 corridor to provide background data for the study and a method for ongoing analysis of impact of the program.
- Dr. McElligott and Dr. Summer are designing a study focusing on school nurses as the missing cornerstone of the Medical Home.
- Dr. McElligott is discussing with Gaye Douglas the collection of case reports on children who have had or are having difficulty obtaining assistance from specialists who don't accept their insurance for use as a compelling illustration of the need for help from legislators.
- CLIA waivers for the schools is being pursued to allow for point-of-care testing in the schools.
- Mail order prescription options are being explored.
- Dr. McElligott presented a report of this telemedicine work at the First Annual Telehealth Summit of South Carolina and South Carolina's 16th Annual Rural Health Conference.
- Dr. McElligott was appointed IT Medical Director for Telehealth in MUSC's telemedicine program, and is working to develop, coordinate, and centralize telemedicine efforts throughout the hospital and external sites. The development of telemedicine capabilities and expertise at MUSC will add to the sustainability of this school-based program.
- State legislators have granted \$12M in support of the MUSC Telehealth efforts, due in part to our presentations to the state legislature regarding its importance. Additional funds have also been added to support elements of the MUSC telehealth program from the Duke Endowment. Dr. McElligott leads MUSC's Telehealth Operations and Development Council and MUSC administration to ascertain the appropriation of these funds. Legislators are discussing further allocation of state funds for use in growing and developing the telemed programs at MUSC. Legislative and lobbying efforts continue to ensure reimbursement for school-based telemedicine. The success of this school program will be instrumental in continued funding.

Collaboration with other SEVIEW projects:

- Monthly meetings of Dr. McElligott's Telemed Work Group are held to facilitate directives of his Telemed Operations and Development Council. These groups are working to develop and integrate the telemedicine efforts of MUSC specialties and subspecialties internally and with external sites.
- Dr. McElligott continues to work with both the VTCC and REACH project investigators towards the goal of establishing sustainable telemedicine programs that benefit underserved areas.

- The SE VIEW investigators who are involved with school-based interventions continue to meet and exchange experience, advice and collaboration ideas.
- Additional collaboration is ongoing between the STEER and Healthy People in Healthy Communities initiatives, which both have their focus on Williamsburg County.
- Dr. McElligott presented the project to the local Medical Board that represents the Healthy People in Healthy Communities, a SE VIEW program also present in Williamsburg County. This will serve to streamline community interaction as the Healthy People group has successfully integrated their healthy lifestyle interventions into the community.

Dr. McElligott has engaged in parallel institutional activity in the field of telemedicine:

- State legislators have granted \$12M in support of the MUSC Telehealth efforts, due in part to Dr. McElligott's efforts. A Duke endowment of nearly \$1M has also been granted. He is working with the Telemed Operations and Development Council and MUSC administration to ascertain the appropriation of these funds. Legislators are discussing further allocation of state funds for use in growing and developing the telemed programs at MUSC.
- Dr. McElligott was appointed IT Medical Director for Telehealth in MUSC's telemedicine program, and is working to develop, coordinate, and centralize telemedicine efforts throughout the hospital and external sites.
- Dr. McElligott traveled to Arkansas to observe their telemedicine program.
- Dr. McElligott has worked as an acting member of the Carolina Connections group, consisting of various stakeholders from around the state including the Office of Rural Health, AHEC and the Hospital Association, to make a statewide telemedicine network in partnership with the Georgia Tele-health Resource Center. Dr. McElligott as member of the subcommittee for this group has worked to formulate a plan to address the legislative components needed to achieve the goal of a statewide network. This legislation has been drafted and introduced to State Congress. It will be re-introduced next year.
- Dr. McElligott is an advisor on a school-based telemedicine project in Chester Co., SC. This project has obtained the telemedicine equipment is currently in the installation and training phase.
- Dr. McElligott is pursuing grant funding to augment the psychiatric services that would be available to telemedicine sites, including the Williamsburg schools.
- The MUSC Department of Pediatrics, through Dr. McElligott, has partnered with AHEC to provide education through the SCHOOLS tele-education program, with monthly morning report presentations underway and grand rounds presentations planned.
- Dr. McElligott has worked to formulate a plan to address the legislative components needed to achieve the goal of a statewide telehealth network. This legislation was drafted and introduced to State Congress.
- Dr. McElligott continues to staff a school based telemedicine clinic at Meeting Street Academy in Charleston, SC with telemedicine equipment for their outreach program, which will inform the clinical operations in Williamsburg.

KEY RESEARCH ACCOMPLISHMENTS:

Basic demographic data is displayed below comparing the urban pilot site with rural site. Though more data are needed, early indications suggest that the age of the child seeking care may include a broader range of ages in the rural region and a higher rate of insured patients.

Table 13: Basic Demographic Data – Urban Site vs. Rural Site

	Urban	Rural	Total
Mean Age in Years	5.5	10.3	6.3
Most Common Diagnosis	Rash, Asthma, Pink eye	Ear pain	Rash
Medicaid	68%	67%	67%

Private Insurance	21%	0%	18%
Uninsured	0%	33%	6%
Medicaid Lapsed or Pending	11%	0%	9%

Baseline data has confirmed access issues in the region that includes Williamsburg County (I-95 Corridor) for young children. These comparisons were determined for at-risk young children, as these high utilizers of health care are indicators of disparities. The follow-up studies underway will determine more specific patterns of health care utilizations for school-aged children, including a determination of any relationship between outpatient visits (or a lack of) with increased preventable emergency room and inpatient visits. The specific utilization patterns of the children enrolled in the program will be compared with these baseline rates. Table 14 illustrates the disparity in health care access points for young children in the region.

Table 14: Healthcare Access Points for Young Children

Healthcare Access Markers by County Grouping				
	I95	Other Rural	Urban	P value
Number of Counties	12	13	21	
Mean number of physicians per 10,000 population	8	12	17	.2
Mean number of physicians per 100 square miles	4	14	51	.03
Mean number of hospital beds per 100 square miles	12	25	56	.03

Table 15 illustrates a disparity in the region for the use of preventive care.

Table 15: Disparity for Use of Preventive Care

	I-95	OTHER RURAL	URBAN	p value
MEAN ANNUAL WELL VISITS	4.9	5.7	5.6	<.01
MEAN ANNUAL OFFICE BASED SICK VISITS	8.2	9.6	12.8	<.01

% WHITE	26%	50%	41%	<.01
% MALE	52%	51%	53%	.75
% MOM WITH HIGH SCHOOL EDUCATION	67%	60%	62%	.12
% TEEN MOM	80%	76%	76%	.24

Tables 16-17 demonstrate that these rural populations are seen in the emergency room and are admitted more frequently than urban areas for conditions that are often preventable. Interestingly, the rural region with more access had relatively more visits despite having better preventive care, indicating that the access points themselves lead to increased visits. This indicates that healthcare utilization patterns are best compared within like regions, as regional geographic factors can influence the analysis.

Table 16: Odds of and ED or IP Visit - Other Rural vs. Urban

ODDS OF AN ED OR IP VISIT: OTHER RURAL VS URBAN		
TYPE OF VISIT	ODDS RATIO	CONFIDENCE INTERVAL
ED	1.49	1.21-1.83
IP	1.40	1.17-1.67

Table 17: Odds of an ED or IP Visit – I=95 vs. Urban

ODDS OF AN ED OR IP VISIT: I-95 VS URBAN		
TYPE OF VISIT	ODDS RATIO	CONFIDENCE INTERVAL
ED	1.42	1.10-1.84
IP	1.12	0.90-1.40

CONCLUSION:

This effort intends to establish a sustainable method of alleviating barriers to healthcare access among children in a rural, underserved area with the use of telehealth technology. An emphasis on community partnership with Medical University of South Carolina is a key component to the program. The past year was utilized to establish the relationships between MUSC and Williamsburg providers, put appropriate contracts in place, establish workflows, purchase and put in place telehealth technology and provide training sessions. The urban pilot site in Charleston matured over the year, with a weekly telehealth presence providing over 60 consultations for a small school. Additionally, asthma specialist services were developed and introduced to the pilot school. The two established Williamsburg County schools began clinical services in the spring at both sites, with a handful of visits under their belts. The school nurses and leadership felt that a full roll-out would be best coordinated at the beginning of the 2013-2014 school year, and this past summer was utilized to prepare for this roll-out which is now underway.

PROJECT TITLE: Evaluating a Media Strategy – Closing the Gap in Healthcare, Inc.

DIRECTOR: Marvella Ford, PhD

The Scientific Context of the “Evaluating a Media Strategy to Provide Health Messages to Medically Underserved Populations in South Carolina” Project

Closing the Gap in Healthcare, Inc. (CGHI) incorporates a series of radio broadcasts that provide health messages to medically underserved populations in South Carolina with low health literacy. The health messages are delivered through radio broadcasts. Thus, CGHI is a health communication strategy. In the Health Communication chapter of Healthy People 2010 (the national health promotion and disease prevention agenda) the authors define effective health communication as “the study and use of communication strategies to inform and influence individual and community decisions that enhance health.”¹

CGHI broadcasts on radio stations that have predominantly African American and/or underserved audiences. The broadcasts occur as frequently as eight times a day starting at 6:30am and ending around 7:30pm daily. Each week, a health tip is broadcast. Past health tips have included “African American Women and Breast Cancer,” “A Husband’s Story of Breast Cancer,” and “Aging Gracefully.”

The mission of CGHI is to decrease health disparities by providing evidence-based health information.

To date, no formal evaluation of the impact of CGHI has been conducted. To address this issue, we will systematically obtain the information needed to refine the design, implementation, and quality of CGHI. To accomplish this aim, we will conduct focus groups with members of communities from the broadcast coverage areas of the radio stations on which CGHI is aired.

The purpose of the focus groups is to assess CGHI by evaluating responses to focus group questions based on the 11 attributes of effective health communication shown in the adjacent table. We will ask general questions related to focus group participants’ sources of health information, and their perceptions of disparities.

African Americans are the primary focus of the information presented through CGHI. However, South Carolina is home to a unique cultural group, the Sea Island population. This is the most genetically homogenous group of blacks in the United States and the group has distinctive cultural practices, including an English-based Creole language containing many African words, unique cuisine, and strong family ties.

Therefore, to include the perspectives of people of Sea Island ancestry in the evaluation, we will conduct focus groups in the Sea Island areas of South Carolina that are included in the broadcast region in addition to other areas of the region.

Attributes of Effective Health Communication
<ul style="list-style-type: none"> ■ Accuracy: The content is valid and without errors of fact, interpretation, or judgment. ■ Availability: The content (whether targeted message or other information) is delivered or placed where the audience can access it. Placement varies according to audience, message complexity, and purpose, ranging from interpersonal and social networks to billboards and mass transit signs to prime-time TV or radio, to public kiosks (print or electronic), to the Internet. ■ Balance: Where appropriate, the content presents the benefits and risks of potential actions or recognizes different and valid perspectives on the issue. ■ Consistency: The content remains internally consistent over time and also is consistent with information from other sources (the latter is a problem when other widely available content is not accurate or reliable). ■ Cultural competence: The design, implementation, and evaluation process that accounts for special issues for select population groups (for example, ethnic, racial, and linguistic) and also educational levels and disability. ■ Evidence base: Relevant scientific evidence that has undergone comprehensive review and rigorous analysis to formulate practice guidelines, performance measures, review criteria, and technology assessments for telehealth applications. ■ Reach: The content gets to or is available to the largest possible number of people in the target population. ■ Reliability: The source of the content is credible, and the content itself is kept up to date. ■ Repetition: The delivery of/access to the content is continued or repeated over time, both to reinforce the impact with a given audience and to reach new generations. ■ Timeliness: The content is provided or available when the audience is most receptive to, or in need of, the specific information. ■ Understandability: The reading or language level and format (including multimedia) are appropriate for the specific audience.

Statement of Work

Task 1. Develop a focus group moderator's interview guide to assess participants' perceptions of the extent to which the CGHI meets the 11 attributes of health communication

Task 2. Conduct 12 focus groups within the broadcast coverage area of the Closing the Gap in Healthcare, Inc. radio broadcasts

Task 3. Evaluate the focus group results

KEY RESEARCH ACCOMPLISHMENTS:

Task 1.

Develop a focus group moderator's interview guide to assess participants' perceptions of the extent to which the CGHI meets the 11 attributes of health communication

This task has been completed. The project team (Drs. Ford, Spruill, Bryant, Lapelle and Ms. Jefferson) developed the focus group moderator's guide that will be used in the focus groups. The moderator's guide is included in **Appendix B**. The MUSC IRB approved it for use in the study.

MUSC Institutional Review Board (IRB) renewal approval to conduct the study was received on August 5, 2012 and on August 2, 2013. The team also developed the other study materials, including the recruitment flyer, the eligibility screener, the recruitment follow-up letter, and the MUSC IRB-approved and stamped consent form. All of these items have received MUSC IRB approval.

Task 2.

Conduct 12 focus groups within the broadcast coverage area of the Closing the Gap in Healthcare, Inc. radio broadcasts

The project team has identified the cities/towns where the focus groups will take place and eight of the 12 planned focus groups have been conducted to date. The distribution of cities/towns was based on the geographic region covered by the Closing the Gap in Healthcare, Inc. radio broadcasts. The cities/towns are described below.

CITIES/TOWNS WHERE FOCUS GROUPS ARE BEING CONDUCTED

Given the large geographic region of the broadcast coverage area of CGHI, we are conducting 12 focus groups within the broadcast coverage area. The focus groups that will be conducted in the Sea Islands will likely be culturally homogenous as well as racially homogeneous. The statewide geographic locations of the cities/towns where the focus groups are being conducted are listed below:

Sea Islands (4)

- Eutawville/Edisto
- Huger
- Wadmalaw Island
- Young's Island

Other Locations (8)

- Bamberg
- Charleston
- McClellanville/Awendaw
- Moncks Corner/Goose Creek
- North Charleston
- Summerville/Ladson
- Walterboro

- West Ashley/James Island

Recruitment of Focus Group Participants

A South Carolina-based marketing firm, Coastal Focus, advertised the study using its statewide database of potential participants. The database was initially built in 1978. It has been continuously updated by including the socio-demographic characteristics and contact information of all prior focus group participants as well as information of individuals whom they have referred to the marketing firm. Coastal Focus, using magazine subscription lists and community advertisements in South Carolina, constructed the database. Coastal Focus will send the people in its database a cover letter describing the study along with the MUSC IRB-approved study flyer. Both documents will state that people who want to take part in the focus groups should call the study coordinator to state that they would like to participate.

It is important to note that while Coastal Focus conducts the initial study recruitment, the MUSC study staff conducts screening of potential participants. Coastal focus does not have a Federal Wide Assurance number and is therefore not eligible to conduct the participant screening activities.

The study coordinator (SC) and/or research assistant (RA) call each potential focus group participant to conduct a short MUSC IRB-approved eligibility screen (included in Attachment C) to ensure that he/she is African American and ages 21 years and older. The SC and/or RA then send eligible and interested people written confirmation of their focus group date, time, and location. The SC and/or RA call participants the night before their scheduled focus group session to remind them of the session.

The focus group structure follows Kohler et al's² suggestion to include about 8–10 participants in each focus group. To obtain this number, we invite 15 participants to each group.

Consenting

Prior to each focus group, informed consent forms are distributed and signed by all participants. Each participant receives two identical copies of the informed consent form. They are asked to sign and date both forms. The investigator who will conduct the focus group also signs both consent forms. Participants then keep one copy of the signed form and the investigator retains the other copy of the signed form for the study files.

To minimize any possible coercion, all potential participants are consented individually. Therefore, upon entering the room that the focus group will be held, each potential participant is given the opportunity to review the consent form. After they are finished reviewing the consent form, they are instructed to go to a private room with the study investigator to address any additional questions and/or concerns, and after all questions and concerns are discussed and the participant agrees to participate, the participant also signs the consent form in the private consultation area.

Focus Group Procedures

After all informed consent forms are signed, each participant completes a short background form to denote his/her sociodemographic characteristics. After the short background form is completed, the focus groups begin with an icebreaker in which each participant is asked to describe his or her dream vacation. Each focus group sessions lasts approximately 1.5 - 2 hours. A snack is provided during the session. Following the completion of each focus group session, each participant signs a receipt and then receives a \$55 gift card honorarium.

Each 2-hour focus session is audiotaped. No personal identifiers are reported in focus group and interview transcripts. If a participant states that he or she does not wish to be audiotaped during the focus group session, the participant is excused from the focus group. Only study staff will have access to the study information, and no participant will be identified by name in any reports or publications resulting from this study.

February 21-22, 2013 (31 participants):

The participants were fairly evenly divided between those who were less than 50 years of age and those who were in the 51-75 year age range. Only one participant (3.2%) reported being of Hispanic ethnicity. All participants reported having African American race, which was the focal population for the study. Five participants (16.1%) reported a high school degree as the highest level of education they had received and one (3.2%) reported having received some post-high school education. One participant (3.2%) reported receiving post-high school training other than college and almost half (n=15, 48.4%) reported having at least a college education. The majority of participants (n=18, 58.1%) reported being married or living as married. The participants were fairly evenly divided between those who reported earning less than \$40,000 per year (n=15, 48.4%) and those who reported earning \$40,000 or more per year (n=16, 51.6%). The majority of participants were female (n=20, 64.5%) although males were fairly well represented.

May 22-23, 2013 (54 participants):

The majority of participants reported being greater than 50 years old (n=34, 63.0%). Only one participant (1.9%) reported being of Hispanic ethnicity. All participants reported having African American race, which was the focal population for the study. Eight participants reported having less than a high school education (14.8%) and ten reported a high school degree as the highest level of education they had received (18.5%). Eight participants reported having received post-high school training other than college (14.8%), 17 reported having received some college education (31.5%), and 11 reported having at least a college education (20.4%). The majority of participants (n=38, 70.4%) reported being single. Most participants reported earning less than \$40,000 per year (n=42, 77.8%). The majority of participants were female (n=32, 59.3%) although males were fairly well represented.

Task 3.

Evaluate the Focus Group Results

Evaluation of the focus group data is ongoing based on a detailed analysis plan. Data are not yet available.

The purpose of the analyses is to evaluate the extent to which the coded data and themes from the focus groups indicate the effectiveness of the CGHI radio broadcasts in meeting the 11 attributes of effective health communication. The questions that are asked during the focus groups correspond to the content domains of the 11 attributes of effective health communication.

The investigators are in the process of grouping the data from the focus group participants into categories or themes related to the 11 attributes using the methods described below. The investigators will then evaluate the extent to which all 11 attributes are reflected in the data. The study results will indicate the effectiveness of the CGHI radio broadcasts.

To conduct the analyses, the investigators are using Microsoft Word to code and retrieve qualitative data, based on the methods developed by Dr. Nancy LaPelle. She is a national expert in qualitative analysis. Our process for using Microsoft Word for coding and retrieval of qualitative data includes seven steps:

1. Format the data into data tables including participant ID information and utterance sequence numbers.
2. Develop a theme codebook in tabular format to define linkages between numeric codes and theme categories. Logically organize the codebook based on the framework or report outline.
3. Determine face-sheet data categories on which retrieval will be done and add columns to the data tables to accommodate coding for these.
4. Do the thematic coding in the theme code column modifying the table as needed to handle text that should be coded with multiple themes.
5. Sort the data by desired face-sheet data and theme code categories to look for patterns.
6. Validate the coding within a data table, correct and re-sort.

7. Merge appropriate data tables and validate coding across data tables. (Optional)

REPORTABLE OUTCOMES:

Anticipated Products

The study results will inform the current gap in knowledge about the extent to which the CGHI is perceived to incorporate the 11 attributes of effective health communication and whether these perceptions are different in African Americans of Sea Island ancestry vs. those who are not. The results will also lead to the development of peer-reviewed manuscripts. In addition, the results will provide preliminary data for a larger grant proposal to expand/ modify/refine the CGHI and test the outcomes of these modifications.

Program Sustainability

Four proposals were funded during the year to support leveraging non-SE VIEW financial resources for project sustainability.

5R01MD005892-01	04/01/2012 - 03/31/2017
(Multiple PIs: Ford and Esnaola)	\$1,250,000
NIH/NCMHD	

Improving Resection Rates among African Americans with NSCLC

The purpose of this study is to evaluate the impact of a dynamic, patient navigation intervention in reducing potential barriers to surgical cancer care and improving resection rates among African Americans with early stage non-small cell lung cancer (NSCLC). We will test the intervention in a two-arm, cluster-randomized trial comparing the intervention versus enhanced usual care in a sample of 200 African Americans in SC with Stage I or II NSCLC. Study participants will be recruited from 6 geographically diverse study sites within a statewide, Cancer Clinical Trials Network.

Role: Multiple Principal Investigator: Ford

W81XWH-12-1-0043 (PI: Ford)	03/01/2012 – 02/28/2015
DOD/CDMRP	\$198,931

The South Carolina Collaborative Undergraduate HBCU Student Summer Training Program. (03/01/2012 – 02/28/2015), \$184,216.

The South Carolina Collaborative Undergraduate HBCU Student Summer Training Program

The **goal** of the Training Program is to provide research training activities to **12** students over a 3-year period from three Historically Black Colleges and Universities (HBCUs) in South Carolina: Claflin University, South Carolina State University, and Voorhees College. The three **aims** of the Training Program are to (1) provide training in the basics of research design and methods to undergraduate students per year from the three HBCUs, (2) to immerse four students per year in prostate cancer research, and (3) to implement a unique dual-level research mentoring strategy for the students.

Role: Principal Investigator: Ford

1 U24 MD006941-01	10/01/2011 – 09/30/2016
(PI: Tilley, Site PI: Mainous; Co-Investigator: Ford)	
NIH/NIA	\$812,244

A Randomized Recruitment Intervention

We propose a randomized trial of a recruitment intervention to increase racial/ethnic diversity. For more common diseases such as hypertension, community approaches have successfully increased diversity in clinical trials, but are less successful when the disease is less prevalent and persons with the disease are more difficult to contact through these targeted community approaches. Our intervention will focus on specialty clinics where treatment trials for low prevalence diseases are usually conducted. The target of the intervention will be the specialists and clinical trial coordinators. The intervention is derived from approaches to changing provider behavior and improving healthcare quality (specialists) and methods

similar to those used in patient navigation to assist racially/ethnically diverse patients in navigating the healthcare system (coordinators). Clinical site will be the unit of randomization.

Role: Co-Investigator: Ford

5P20CA157066-01(PI: Ford) 09/26/2011 - 08/31/2015

NIH/NCI \$511,597

SC Cancer Disparities Research Center in Prostate and Breast Cancer (SC CaDRe)

The essential purpose of the SC CaDRe is to create a partnership between SC State University and the Medical University of South Carolina to expand cancer disparities research in South Carolina while cultivating a network of diverse cancer research scientists.

W81XWH-11-2-0164 (PI: Slaughter; Multiple PI: Ford) 09/01/2011 – 09/30/2013

DOD/ Dept. of the Army – USAMRAA \$281,138

Southeastern Virtual Institute for Health Equity and Wellness (SE VIEW) Phase II

This initiative will evaluate the impact of a communication strategy to deliver evidence-based health information to medically underserved, rural and urban African Americans, including a unique group, the Sea Island Gullah population, with distinctive cultural practices and a Creole language containing many African words. A focus group approach will be used to assess the Closing the Gap in Healthcare, Inc. radio broadcast based on the 11 attributes of effective health communication.

5R21CA 152865-01 (PI: Ford) 09/01/2011-8/31/2014

NIH/NCI \$275,000

Optimizing Survivorship and Surveillance after Treatment for Colon Cancer

The purpose of this R21 study is to systematically investigate the role of multilevel factors on participation of colon cancer survivors in guideline-based post-treatment surveillance and care. Specifically, we will evaluate the role of personal factors (e.g., knowledge, attitudes and sociodemographics) and health care system factors (e.g., specialist-primary care communication, insurance) as contributors to survivor care experiences and outcomes.

Most recently, on August 22, 2013, the following grant was awarded:

3P20CA157071-03S1 (PI: Ford) 09/01/2013-08/31/2015

NIH/NCI \$114,396

SC Cancer Disparities Research Center (2 of 2) (Research Supplements to Promote Diversity in Health Related Research)

CONCLUSION:

As described in the preceding pages of this report and by evidence documented in the attachments, the investigators have made substantial and quantifiable progress toward meeting the tasks listed in the Statement of Work.

In addition to developing a focus group moderator's guide, the project team also developed other study materials, including a recruitment flyer, an eligibility screener, and a recruitment follow-up letter. A marketing firm identifies potential participants who are screened for eligibility by project staff. Eight of the 12 focus groups have been conducted and data from them are being analyzed using a detailed analysis plan developed by the investigators.

REFERENCES:

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PROJECT TITLE: Community Based Participatory Research (CBPR) to Improve Oral Health

DIRECTOR: Renata S. Leite, DDS

The proposed study is designed to test the feasibility of a bundled, multi-level intervention, whose design is based on the preferences of the targeted rural population. The CAD/CAM system is a new technology that could be used by the military during treatment delivery to speed up the treatment time and reduce laboratory fees, and still provide state of the art esthetic prosthetic therapy. A social-ecological model is proposed to guide the intervention, providing a framework for intervening at multiple levels of influence (individual, peer and organizational) on oral health behaviors. By improving the oral care and oral health literacy of communities as a whole we will be improving the oral health of potential military recruits, decreasing the time spent on improving recruits oral health just prior to their active recruitment, therefore decreasing delays in recruitment due to poor oral health and decreasing the dollar amount spent with oral care.

Research findings demonstrate complex barriers impede prevention and early treatment of oral health diseases in disadvantaged groups¹. According to our formative study², these barriers include fear³; history of unpleasant experiences^{4,5}; being under- or uninsured^{6,7}; low health literacy and education levels⁸; cultural orientations that contribute to lack of trust⁹; logistic barriers of transportation, clinic schedules, and rural residence^{10,11}; and difficulties negotiating relationships with healthcare providers¹². Prior studies reveal that academically led individual level interventions do not improve oral health outcomes¹³. The use of a community preferred, multi-level and locally relevant intervention is a promising approach to address oral health disparities in this population.

The African American (AA) Gullah population along the Southeastern U.S. sea coastal regions are a direct descendant population of rice plantation enslaved Africans from West Africa¹⁴. Gullah refers to several things: language, people, and a culture. The Gullah today have a considerably lower level of non-African genetic admixture as compared to other AA groups¹⁵, which is thought to be due to their longtime geographical, social and cultural isolation¹⁶. When compared to other AAs, the Gullah face profound OH disparities. Fernandes *et al.* found significantly higher prevalence rates of PD among Gullah AA (70.6%) as compared to national estimates of AAs (31.3%)¹⁷. The mean total number of missing teeth among the Gullah is significantly higher at 8.3 (se= 0.42;range: 0-25)¹⁷ when compared to means reported in the National Health and Nutrition Examination Survey (NHANES) 1988-1994 and 1999-2002 among dentate non-Hispanic black adults of 6.87 (se=0.15) and 5.78 (se=0.14), respectively (p<0.01)¹⁸, demonstrating that extraction is the treatment of choice in this population. For severely damaged/ broken down teeth the treatment options in a public health clinic is either extraction or a large posterior resin restoration, which may not be as resistant as ceramic restorations. Extractions and restorations that do not provide long-term resolutions may have a negative impact on an individual's oral health-related quality of life¹⁹. Furthermore, the loss of teeth may perpetuate poor oral hygiene²⁰. Ceramic restorations have not been made available to low socio-economic populations as an option for restorative care due to the cost of fabrication and compliance required with a second visit for delivery of the restoration. However, using a new CAD/CAM system (CEREC AC; Sirona, Charlotte, NC) all ceramic restorations can be fabricated for severely broken down teeth in one office visit overcoming the compliance requirement and with no additional high laboratory fee associated with the fabrication of ceramic restorations. The approaches we have identified to intervene with this community, although used with other health promotion interventions, are novel in the field of oral health and include: use of community-based participatory research (CBPR) approach to design and test an oral health intervention; the use of a community oral health promoter

(COHP); the use of multi-level or ecological approaches to influence individual and community-level changes; and the use of high technology (CEREC system) to provide high end prosthodontic care at low cost and on a productive time frame, suitable for community/outreach clinics. The academic-community partnership approach has been recommended by Healthy People 2010²¹, the Institute of Medicine²² and others²³⁻²⁵ as a strategy to eliminate health disparities. The partnership between the James B. Edwards College of Dental Medicine, Our Lady of Mercy Community Outreach Clinic in Johns Island, SC and the community advisory board (CAB) has developed into a capable partnership able to implement this proposed application.

Over the past decade, patient navigators have been used to help patients access and overcome barriers to receiving quality cancer care²⁶. More recently, patient navigators have been examined in primary care to extend a provider's reach in promoting adherence to preventive health recommendations^{27, 28}. Navigators play a reactive role by trouble-shooting problems, while community workers, such as lay health educators, inform patients about the importance of adherence to a particular healthy behavior²⁹. Compared to navigators, educators are more proactive in addressing specific barriers. We propose to utilize a layperson to work in a combined role of educator and navigator to address the barriers and improve oral health outcomes.

KEY RESEARCH ACCOMPLISHMENTS:

Aim 1. Develop a novel, community preferred OH multi-level intervention in church settings.

To develop/refine church level, group education/behavioral level, and individual level COHP training and treatment protocols; establish COHP recruitment process; and, evaluate participants' identification and recruitment processes and retention.

- Investigators have been meeting with church leaders involved in the study to better develop and refine the church level strategy;
- The Oral Health handbook to be used with the group education/behavioral level intervention has been tested using community focus groups, following the CBPR approach;
- A Community Oral Health Promoter (COHP) has been hired and trained;
- Participants are being identified with the help of Church leaders.

Aim 2. Evaluate intervention feasibility including intervention dosage and fidelity as well as monitoring and measurement of target outcomes.

To develop intervention monitoring, supervision, fidelity protocols and process evaluation; and to design and pre-test activity monitoring.

- Intervention monitoring, supervision and fidelity protocols and forms have been developed.

Aim 3. Evaluate preliminary efficacy indications of the intervention and estimate outcome measurement variability needed to calculate sample size for a subsequent study of intervention efficacy.

We hypothesize that participants randomized to the intervention group (n=20) will demonstrate improved OH, OH literacy and OH self-efficacy and decreased dental anxiety with fewer occurrences of broken appointments as compared to those in the CG (n=20).

- MUSC IRB approval received on December 20, 2012;
- Protocol submitted to DoD for review and approval on January 16, 2013;
- Protocol re-submitted to DoD for review and approval on March 15, 2013;
- Protocol reviewed by the US Army Medical Research and Materiel Command (USAMRMC), Office of Research Protections (ORP), Human Research Protection Office (HRPO) and granted initial approval on August 13, 2013;
- Participants' recruitment will start in two weeks.

REPORTABLE OUTCOMES:

1. Spruill I, Leite RS*, Fernandes J, Kamen DL, Ford ME, Jenkins C, Hunt K, Andrews J. Two Decades of Successes, Challenges, and Lessons Learned: Community Based-Scholarship and Community Engaged Research among the “Gullah” Population of South Carolina. *Int J Community Research and Engagement*. 2013. 6(1):XX. In press.
2. Andrews JO, Cox MJ, Newman SD, Gillenwater G, Warner G, Winklwer J, White B, Wolf S, Leite RS, Ford M, Slaughter S. Training Partnership dyads for CBPR: Strategies and Lessons Learned from the Community Engaged Scholars Program. *Health Promotion Practice*. 2013. 15(4): 524-533.
3. Leite RS, Hudson CM, West LI, Carpenter EM, Andrews JO. Assessment of oral health disparities among the Gullah population of Hollywood, SC – Hollywood Smiles. Aging Research Day. Charleston, SC March 8th, 2013.
4. Health Resources and Services Administration (HRSA) grant T12HP24722. The South Carolina Oral Health Safety net Enhancement Portfolio: Improving Access to care through Innovative Oral Health Workforce Approaches (PI: Martin – Univ of South Carolina; MUSC Co-I: Leite).

CONCLUSIONS:

There are significant benefits associated with this protocol. This study is design to test the feasibility of a bundled, multi-level intervention, whose design is based on the preferences of the targeted rural Gullah community. If this study demonstrates feasibility in recruitment and retention of Gullah participants, acceptability of church members, and preliminary signals of efficacy, we will broaden our recruitment for the future R01 with other Gullah communities in the state.

Despite major improvements in oral health for the general population, oral health disparities exist for many racial and ethnic groups, by socioeconomic status, gender, age and geographic location. When compared to other African Americans, the Gullah face profound oral health disparities. There are 9 counties identified as the Gullah homeland and or the Sea Islands of SC, primarily Beaufort, Charleston, Berkeley, Dorchester, Colleton, Horry, Georgetown, Hampton, and Jasper, which will allow replication and testing of the intervention in multiple churches in multiple counties, therefore allowing us to decrease oral health disparities throughout the Southeastern US. The use of the CAD/CAM technology to provide all ceramic restoration to low socioeconomic communities will allow a decrease in the cost involved previously with this type of restorations.

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PROJECT TITLE: Patient Risk Assessment and Health Education with Computer Kiosks in Community Health Centers

DIRECTOR: Arch G. Mainous, III

The aims of this study are to determine whether an interactive computerized health-linked lifestyle behavior questionnaire in a community health center waiting room that generates summary printouts for physicians immediately prior to a primary care visit can: (1) improve participants' awareness of their unhealthy lifestyle behaviors; (2) improve communication between participants and their doctors about how to transition to healthier lifestyle behaviors; and (3) provide participants with the knowledge and motivation that they need in order to make changes to their lifestyle behaviors to enable them to live healthier lives and reduce the incidence of preventable diseases. We will compare these outcomes at three different time points over the course of a year of participant data (baseline, 1 week after baseline, 6 months after baseline, and 12 months after baseline) in two groups of informed and consenting participants (approximately 150 persons in each group of suitable age for military recruitment, 18-35 years old): (1) the interactive health behaviors kiosk questionnaire and summary printout for physician immediately prior to primary care visit group (intervention group), and (2) the interactive health behaviors kiosk questionnaire immediately after primary care visit group (control group). We hypothesize that participants in the intervention group, who will have the opportunity to interact with their physician about kiosk-identified unhealthy lifestyle behaviors shortly after completing the interactive kiosk questionnaire, will show more improvement in the above outcomes than participants in the control group after 12 months of follow-up.

Current Status:

We started survey implementation and recruitment in December, 2012 and, as of 7/26/2013 have recruited 175 subjects (58.3% of total recruitment completed), 84 in the intervention group and 91 in the control group. We will continue recruitment until we reach the planned 300 baseline subjects, 150 from each site. We will then follow all subjects with week 1, month 6, and month 12 surveys to assess change over time. Once all data is received, we will conduct data analyses, report on our finding, and pursue publication of these results.

Current status of data follow-up:

We have a follow-up rate of 77% for week 1 follow-up (135 of 175 subjects) and 67% for month 6 follow-up (26 of 39 subjects needing 6 month survey follow-up have received it) so far. We will continue to avidly follow-up with participants via phone and email through the Redcap system to maintain these high follow-up rates.

Preliminary Data:

Below you will find preliminary data assessed from baseline and week 1 by intervention and control groups. We have not included month 6 data as we started recruitment in December so the number of people with needed follow-up to this point is too small to assess (n=26). Because these data are preliminary, we cannot make any conclusions from it at this time. Therefore, we have not included statistical significance tests with these data tables. We will include statistical significance tests, as well as month 6 and month 12 data, when data collection is complete.

Preliminary data, Intervention (n=65) versus Control (n=70) comparing Baseline (B) to Week 1 (W1)

TABLE 18: Key Obesity and Lifestyle Variables by group (%)

	Intervention (n=65)	Control (n=70)
Obese (BMI ≥ 30)	40.0	34.3
Body Mass Index (BMI) (mean, 95% CI)	29.7 (27.9-31.5)	28.6 (26.5-30.8)
Was last week's doctor your usual doctor? (W1)		
Yes	73.9	52.9
αDoctor told overweight or obese? (B)		
Yes	53.1	52.3
No	46.9	47.7
Would you like your doctor to help you lose weight? (B) (Intervention only)		
Yes	63.3	-
No	36.7	-
*Discussed weight with doctor at visit? (W1)		
Yes	50.0	32.7
No	50.0	67.3
Discussed diet with doctor at visit? (W1)		
Yes, definitely	46.2	34.3
Yes, somewhat	12.3	18.6
No	41.5	47.1
Discussed activity with doctor at visit? (W1)		
Yes, definitely	47.7	33.8
Yes, somewhat	13.8	16.2
No	38.5	50.0
Discussed alcohol with doctor at visit? (W1)		
Yes, definitely	32.3	24.3
Discussed tobacco usage with doctor at visit? (W1)		
Yes	55.0	58.3
βWillingness to change eating —baseline (mean, 95% CI)	2.4 (1.9-2.4)	2.0 (1.7-2.2)
βWillingness to change eating —week 1 (mean, 95% CI)	1.6 (1.4-1.9)	1.8 (1.5-2.0)
βChange in willingness -Baseline to week 1	-0.8	-0.2

* only asked if subject wanted to “weigh less” or “stay about the same.”

α only asked if subjects had a BMI ≥ 25

β 1=“very willing to change” 5=“not at all willing” so a decrease from baseline to week 1 is an improvement.

Table 19: Perception of Weight, Diet, and Exercise by Group (%)

	Intervention (n=65)	Control (n=70)
Would you like to? (B)		
Weigh more	18.5	21.4
Weigh less	61.5	57.2
Stay the same	20.0	21.4
Would you like to? (W1)		
Weigh more	16.9	21.4
Weigh less	63.1	58.6
Stay the same	20.0	20.0
Do you think you have a healthy diet? (B)		
Yes	55.4	35.7
No	44.6	64.3
Do you think you have a healthy diet? (W1)		
Yes	50.8	33.3
No	49.2	66.7
Do you think you get enough physical activity? (B)		
Yes	44.6	31.4
No	55.4	68.6
Do you think you get enough physical activity? (W1)		
Yes	42.2	34.8
No	57.8	65.2

Table 20: Demographics and Military Service and Interest by Group (%)

<i>Demographics</i>	Intervention (n=65)	Control (n=70)
Gender		
Female	72.3	64.3
Male	27.7	35.7
Race		
Black	83.3	77.3
White	16.7	16.7
Other	0	6.0
Hispanic		
Hispanic	7.7	5.7
Not hispanic	92.3	94.3
Age (mean, range)	26.2 (18-35)	25.9 (18-35)
Has anyone in your family ever served in the Armed Forces of the United States?		
Yes	56.9	58.6
No	43.1	41.4
Have you ever served in the Armed Forces of the United States?		
Yes	1.5	7.1
No	98.5	92.9
Are you interested in serving in the Armed Forces of the United States in the future? (Only ask if the person answers "No" to the question above.)		
Yes	14.1	13.9
No	85.9	86.1

Table 21: Diet interaction with physician by group (%)

	Intervention (n=65)	Control (n=70)
Was last week's doctor your usual doctor? (W1)		
Yes	73.9	52.9
*Doctor ever told to improve diet? (B)		
Yes	38.5%	39.0%
*Wants doctor's help w/ diet? (B)		(not in control)
Wants help	69.2%	-
Discussed diet with doctor? (W1)		
Yes, definitely	46.2%	34.3%
Yes, somewhat	12.3%	18.6%
No	41.5%	47.1%

* only if 3 or more "Usually/Oftens" responses regarding unhealthy food habits.

Table 22: Change in eating habits by group by group (%)

How often do you...?	Intervention (n=65)	Control (n=70)
[∂] Drink >16 oz non-diet soda a day (B)?		
^a Usually/often	30.8	42.9
[∂] Drink >16 oz non-diet soda a day (W1)?		
^a Usually/often	36.9	29.0
[∂] Eat sweets (e.g., cookies, candy) ≥ 2 times/ day (B)?		
^a Usually/often	30.8	28.6
[∂] Eat sweets (e.g., cookies, candy) ≥ 2 times/ day (W1)?		
^a Usually/often	29.2	18.6
[∂] Eat fried foods? (B)		
^a Usually/often	41.5	42.9
[∂] Eat fried foods? (W1)		
^a Usually/often	38.5	31.4
[∂] Eat <2 servings vegetables a day? (B)		
^a Usually/often	36.9	25.7
[∂] Eat <2 servings vegetables a day? (W1)		
^a Usually/often	32.8	20.9
[∂] Skip breakfast? (B)		
^a Usually/often	44.6	41.4
[∂] Skip breakfast? (W1)		
^a Usually/often	43.1	30.0
[∂] Eat ≥4 meals at restaurants in an average week? (B)		
^a Usually/often	26.2	24.3
[∂] Eat ≥4 meals at restaurants last week? (W1)		
^a Usually/often	30.8	39.1
[∂] Eat <2 servings of whole grains/high fiber starches/day? (B)		
^a Usually/often	27.7	28.6
[∂] Eat <2 servings of whole grains/high fiber starches/day? (W1)		
^a Usually/often	41.5	20.0
[∂] Eat less than 2 servings of fruit a day? (B)		
^a Usually/often	38.5	27.1
[∂] Eat less than 2 servings of fruit a day? (W1)		

	^a Usually/often	30.8	18.6
[∂] Eat less than 2 servings of vegetables a day? (B)			
	^a Usually/often	37.5	25.7
[∂] Eat less than 2 servings of vegetables a day? (W1)			
	^a Usually/often	32.8	20.9
[∂] Eat or drink less than 2 servings of dairy a day? (B)			
	^a Usually/often	31.3	37.1
[∂] Eat or drink less than 2 servings of dairy a day? (W1)			
	^a Usually/often	35.4	28.6
How often do you...?		Intervention (n=65)	Control (n=70)
[∂] Eat >8 oz of meat a day (B)?			
	^a Usually/often	44.6	52.9
[∂] Eat >8 oz of meat a day (W1)?			
	^a Usually/often	50.8	45.7
[∂] Use regular processed meats instead of low-fat versions? (B)			
	^a Usually/often	24.6	22.9
[∂] Use regular processed meats instead of low-fat versions? (W1)			
	^a Usually/often	21.5	25.7
[∂] Eat regular snacks instead of low-fat version? (B)			
	^a Usually/often	33.9	38.6
[∂] Eat regular snacks instead of low-fat version? (W1)			
	^a Usually/often	18.8	25.7
[∂] Add fat to bread, potatoes, rice or vegetables? (B)			
	^a Usually/often	35.4	35.7
[∂] Add fat to bread, potatoes, rice or vegetables? (W1)			
	^a Usually/often	36.9	25.7

[∂] Baseline eating habits were based on “Eating habits in an average week.” Week 1 eating habits were from subject’s reported from “last week.”

^a Focusing on reducing frequent (“Usually/often”) unhealthy eating habits

Table 23: Activity interaction with physician by group (%)

	Intervention (n=65)	Control (n=70)
Was last week’s doctor your usual doctor? (W1)		
Yes	73.9	52.9
*Doctor ever told to improve activity? (B)		
Yes	61.0	64.8
*Wants doctor’s help w/ exercise? (B)		(not in control)
Wants help	61.0	-
Discussed exercise with doctor? (W1)		
Yes, definitely	47.7	33.8
Yes, somewhat	13.8	16.2
No	38.5	50.0

* Only ask if have low reported physical activity

Table 24: Activity habits by group (%)

How often do you...?	Intervention (n=65)	Control (n=70)
Get least 30 minutes of physical activity 3 days a week? (B)		
^a Usually/often	36.9	22.9
Get least 30 minutes of physical activity 3 days last week? (W1)		

Yes	53.9	58.6
Watch more than 2 hours of television or videos a day?? (B)		
^α Usually/often	32.3	52.9
Watch more than 2 hours of television or videos a day last week? (W1)		
^α Usually/often	38.5	33.3

Table 25: Alcohol perception, usage and interaction with physician by group (%)

	Intervention (n=65)	Control (n=70)
Do you drink alcohol? (B) Yes	55.4	52.9
^αDo you think you drink too much alcohol? (B)		
Yes	11.1	13.5
When was the last time you had more than X drinks in 1 day? (B)		
Within the last 3 months	38.9	46.0
3-12 months ago	19.4	13.5
Was last week's doctor your usual doctor? (W1)		
Yes	73.9	52.9
^μHas a doctor ever told you to drink less alcohol? (B)		
Yes	21.4	23.5
^βWould you like your doctor to help you lose weight? (B) (Intervention only)		
Yes	7.1	-
Discussed alcohol with doctor at visit? (W1)		
Yes, definitely	32.3	24.3

α only ask if answered "Yes" to "Do you drink alcohol?"

μ only ask if "within the last 3 months" to binge drinking question

β only asked if classified as a hazardous drinker according to AUDIT-C

Table 26: Tobacco usage and interaction with physician by group (%)

	Intervention (n=65)	Control (n=70)
What is your history of tobacco or cigarette use? (B)		
Current smoker	26.6	20.0
Former smoker	15.6	8.6
What is your history of tobacco or cigarette use? (W1)		
Current smoker	30.8	17.1
Former smoker	18.5	20.0
^βWould you like your doctor to help with tobacco usage? (B) (Intervention only)		
Yes	61.1	-
Was last week's doctor your usual doctor? (W1)		
Yes	73.9	52.9
Discussed tobacco usage with doctor at visit? (W1)		
Yes	55.0	58.3

β only asked if reported being a "Current smoker"

KEY RESEARCH ACCOMPLISHMENTS:

While we were waiting on regulatory approval, we worked on a study that was recently published in *The American Journal of Gastroenterology*. It was a result of work conducted under the SE View project that discovered disparities in bariatric surgery between white and black adults in the US. The article has generated some media attention.

- Article link - <http://www.nature.com/ajg/journal/v108/n8/abs/ajg2012365a.html>
- Pubmed link for article - <http://www.ncbi.nlm.nih.gov/pubmed/23912399>
- US News and World Report - <http://health.usnews.com/health-news/news/articles/2013/08/05/whites-are-heavier-users-of-weight-loss-surgery-study-finds>

REPORTABLE OUTCOMES:

The team has not yet reached this stage of the project.

CONCLUSION:

The team has not yet reached this stage of the project.

REFERENCES:

N/A

APPENDIX A



Junior Doctors of Health[®] Program Ms. Rugg's Class Results



This academic year, student mentors from MUSC encouraged your child to *eat healthy with a diet full of fruits, vegetables, whole grains, low-fat dairy, and lean sources of protein AND to exercise for 60 minutes every day.*

At the completion of the program, your child became an official “Junior Doctor of Health”, giving them **full authority to take control of their own health and to educate their family, friends, and community about the importance of healthy eating and exercise.**

Your students participated in activities to promote self and family healthy eating and exercise:

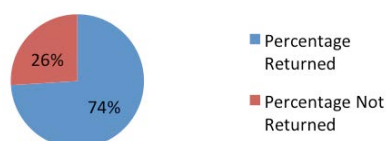
Sign family contracts • Bring Parents • Taste Healthy Snacks • Advocate for Health

Below is a quick summary of our findings to share with parents and teachers how the program is working in the classroom. Thank you for your participation and we look forward to working with you again!

Contracts and Parent Attendance

Results

74% of contracts were returned!

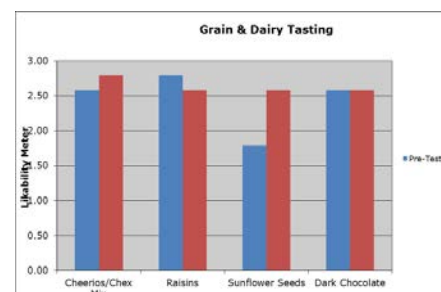
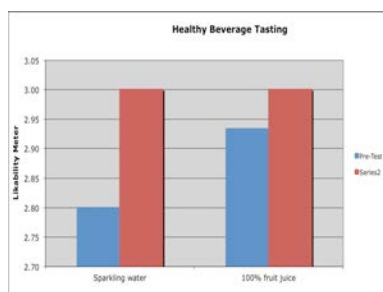
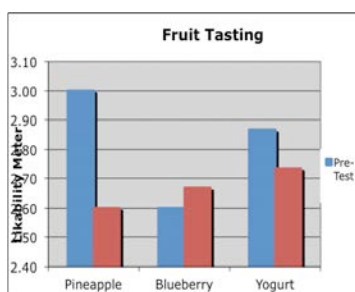


WHAT
does it
mean?

This contract asked for parent to sign a contract with their child to promote a healthy lifestyle for their family, make healthier food choices and exercise at least 60 min a day. Parent involvement is crucial to the health and well-being of a child. As a parent, you are the most important influence in your child's success in school and in life. We hope for continued support and even more contracts next year!

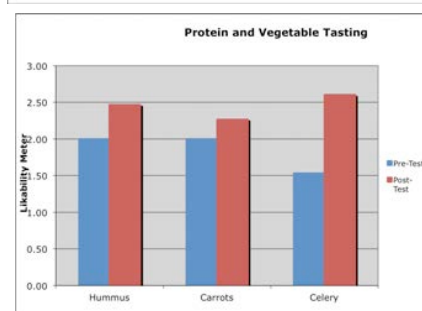
Taste Test

Results

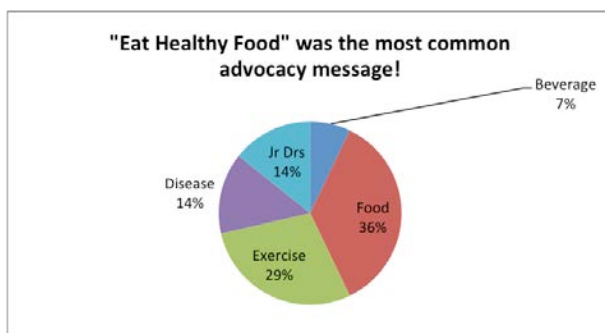


WHAT
does it
mean?

We made healthy snacks during the Junior Doctors of Health program. Students filled out a taste test card before and after eating the healthy snack. Students discovered they liked blueberries, yogurt, hummus, celery, 100% fruit juice, cheerios/chex mix, and sunflower seeds more than they thought they would! These are healthy options for snacks they might enjoy at home.



What did JDOH graduates advocate for?



**WHAT
the kids
said...**

After becoming "Junior Doctors of Health," each student drew a picture or create a message on a poster about something that they would like to change at home, at school, or in their community to improve their healthy eating and drinking habits and/or ability to engage in physical activity. Students' most common health message was to advocate for healthy food!

Your graduation class!



Your participation is greatly appreciated.

We hope for your continued involvement in promoting healthy lifestyle choices with your children!

you have comments or suggestions, please contact Dr. Scotty Buff at 792-0860 or morrowsm@musc.edu

If

APPENDIX B

Moderator's Guide: Marvella E. Ford, Principle Investigator

Study: Evaluating a Media Strategy to Provide Health Messages to Medically Underserved Populations in South Carolina

I. WARM-UP AND EXPLANATION (10 minutes)

A. Introduction

1. Good evening. My name is Marvella Ford. I work at the Medical University of South Carolina.
2. Thanks for coming.
3. Your presence and participation are important. Your thoughts and comments will be valuable in helping us to evaluate the Closing the Gap in Healthcare radio series and improve the health messages delivered through its radio broadcasts.

Purpose

1. What we are doing here today is called a focus group. It's a discussion to find out your opinions -- like a survey.
2. We are interested in all of your ideas, comments and suggestions.
3. Each of you is very important and all of your comments -- both positive and negative -- are welcome.
4. There are no right or wrong answers.
5. Please speak up -- even if you disagree with someone else here. It important that I hear what each of you thinks.

B. Procedure

1. We will be audiotaping our discussion. Everything you say is important to us, and we want to make sure we don't miss any comments. Later we'll go through all of your comments and use them to prepare a report on our discussion. However, all of your comments are confidential and will be used only for research purposes. Nothing you say will be connected to your name. Each of you has been given a nametag with a number on it. You will be referred to by your number throughout the entire focus group session. Therefore, DO NOT state your name when you respond. Also, if any questions make you uncomfortable, feel free not to answer them.
2. You don't have to wait for me to call on you but please speak one at a time, so the tape recorder can pick up everything.
3. We have many topics to discuss so I may change the subject or move ahead. Please stop me if you want to add anything.

Ice Breaker and Introductory Questions

We are looking at a set of criteria that are important to making good health messages. Some of these criteria may be more important than others. Your responses to the following questions will help us to decide which criteria are most important.

What media channels, such as TV, radio, newspapers, or the internet, have been most helpful to you as sources of health information?

How important have the Closing the Gap radio broadcasts been to you or others you know? In what ways have the broadcasts been important to you?

What have been the topics of the Closing the Gap Broadcasts that have been the most helpful to you? How did that information help you?

Availability

1. How good do you feel the radio is as an approach for reaching you with the Closing the Gap health messages? (Probe: What other approaches might be better? E.g., internet, television, magazines, newspapers, Facebook, Twitter, etc.)
2. At what time of day do you typically listen to the Closing the Gap broadcast? (Probe: What are you usually doing while you listen to the broadcast? (E.g., driving, eating, doing household chores, etc.) (Probe: What would be your preferred time to listen to the broadcast? Does it come on at that time? What makes this your preferred time?) (Probe: how does this time fit best into your schedule?)

Timeliness

1. How often have you heard health information on the Closing the Gap broadcasts that was helpful to you? Did you get the information at a time when you really needed it? (Probe: What was going on in your life that made this information most helpful to you?)

Balance

[Play recorded Closing the Gap broadcasts (1 on cancer screening and others on randomly selected topics)]

1. Theodosia character: What are your thoughts about this character? (Probe: was her way of talking helpful in providing health information? If so, in what ways? If not, in what ways?)

2. Do you feel that the Closing the Gap broadcasts provide health information in a fair and or unbiased way? (Probe: If so, what are some examples? If not, what are some examples?)
3. Let's think about an example such as cancer screening. To what extent do you feel that the Closing the Gap broadcasts provide information about how cancer screening can be potentially helpful or harmful?
4. Do you ever get the sense that you are being asked to do health-related activities without fully understanding the pros and cons of these activities? (Probe: what are some examples from the broadcasts?)

Consistency

1. Does the health information that you have received from the Closing the Gap broadcast give the same message as the health information that you have received from other sources? (Probe: If not, do you remember what the differences were? What were the other source(s) of information?)
2. Which source of information do you think was most correct? (Probe: How did you come to this conclusion?)
3. Have other health messages you have heard or read in the media (i.e. newspaper, radio, TV, brochures, magazines) been consistent with the information you have heard on Closing the Gap in Healthcare Broadcasts?
4. Has the information on particular health topics been consistent and or the same throughout the Closing the Gap in Healthcare Broadcasts?

Accuracy

1. How much of the information that you have heard on the Closing the Gap broadcasts do you think was correct?

Reliability

1. To what extent do you trust or believe the information that you have heard on the Closing the Gap in Healthcare broadcasts?
2. To what extent do you trust or believe Dr. Bell as a source of information?
3. Does it matter who delivers the message of the Closing the Gap in Healthcare broadcast? (Probe: Would you still listen if someone else's voice is on it?)

Reach

1. How often do your friends and relatives listen to the Closing the Gap in Healthcare broadcast?

Repetition

1. How often have you noticed that the same Closing the gap broadcasts are being aired? Do you think that the broadcasts are aired enough times? (If so, please state your reasons. If not, please state how often, and when you think they should be aired.)

Cultural Competence

1. Do you believe that the information you hear on the Closing the Gap in Healthcare broadcasts speaks to the culture of African Americans?
2. Do you feel that the health messages are expressed in a way that is culturally correct?
3. Have you ever been offended by the way any of the broadcasts were conducted?

Understandability

1. How often have you heard words or terms in the Closing the Gap broadcasts that you still did not understand when the broadcast had finished? What were those terms?